DEPARTMENT OF HEALTH AND HUMAN SERVICES

FY 2000 PERFORMANCE PLAN SUMMARY

GOVERNMENT PERFORMANCE AND RESULTS ACT

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The Department of Health and Human Services is a large, decentralized Agency that administers approximately 300 program activities. To best accommodate the linkage of performance goals and measures for program activities to the budget requests for these programs, HHS has incorporated the annual performance goals and measures into the budget submissions for the HHS components that administer the programs. For detailed performance information, including performance goals and measures for individual program activities, readers are referred to the annual performance plans included in the budget justifications for the individual HHS components.

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ORGANIZATION OF PERFORMANCE PLAN SUMMARY

This document is a detailed summary of the FY 2000 performance information for HHS that is fully presented in the performance plans of HHS components, contained in the FY 2000 budget submissions for those components. The HHS FY 2000 Performance Plan Summary has been expanded beyond that presented in FY 1999 to provide a clear Departmental focus to program performance assessment under GPRA. The summary describes the Department's priorities for FY 2000 as they have been set out in the President's Budget, and identifies the strategic objectives in the HHS Strategic Plan that each priority will help to achieve. It provides a detailed delineation of the linkages between the FY 2000 performance goals and measures for HHS programs and the strategic objectives of the HHS Strategic Plan. The summary presents an analysis of the nature of crosscutting activities and performance in HHS, and it addresses management improvements that HHS and its components will pursue in FY 2000. It also analyzes common data challenges that HHS must confront with the continued implementation of GPRA. Finally, the summary describes the important elements of the Department's approach to GPRA implementation and performance measurement, and similar information for HHS components. The HHS FY 2000 Performance Plan Summary is organized as follows:

SECTION I – HHS-Wide Priorities and Objectives, Crosscutting Program Activities, Management Issues, and Data Challenges

SECTION II– FY 2000 Performance Activities, Goals and Measures That Support the Achievement of the HHS Strategic Plan

APPENDIX – Approach to Performance Measurement, Measurement Challenges, and Improvements in the Performance Plans of HHS Components

HHS FY 2000 PERFORMANCE PLAN SUMMARY

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SECTION I:

HHS PRIORITIES, CROSSCUTTING PROGRAM ACTIVITIES, MANAGEMENT IMPROVEMENT AND DATA CHALLENGES

The Department of Health and Human Services seeks to enhance the well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services. We accomplish this mission through the separate and collaborative efforts of our operating divisions and staff offices within the Office of the Secretary:

Administration on Aging (AoA) serves as the primary federal focal point and advocacy agent for alder Americans. Through a network of state and area agencies on aging, AoA funded programs deliver comprehensive in-home and community services; and make legal services, counseling, and ombudsmen programs available to elderly Americans

Administration on Children and Families (ACF) leads the nation in improving the economic and social well-being of families, children, and communities though federal grant programs like Head Start, Child Support Enforcement, Child Welfare Services, Child Care and Development, and Temporary Assistance to Needy Families.

Agency for Health Care Policy and Research (AHCPR) supports and conducts health services research and disseminates information to improve clinical care and the organizing and financing of health services; enhances the cost-effective use of health care resources; measures and improves the quality of health care; and enhances access to care.

Centers for Disease Control and Prevention (CDC) monitors health; identifies and investigates public health problems; promotes healthy behaviors; and develops and advocates sound public health policies to prevent and control disease, injury, and disability.

Food and Drug Administration (FDA) promotes improvement in the health of the American public by ensuring the effectiveness and/or safety of drugs, medical devices, biological products, food, and cosmetics; and by encouraging the active participation of business and the public in managing the health hazards associated with these products.

Health Care Financing Administration (HCFA) pays Medicare benefits; provides states with matching funds for Medicaid benefits; conducts research, demonstrations, and oversight to ensure the safety and quality of medical services and facilities provided to Medicare beneficiaries; and establishes rules for eligibility and benefit payments.

Health Resources and Services Administration (HRSA) promotes equitable access to comprehensive, quality health care for all, with a particular focus on underserved and vulnerable populations.

Indian Health Service (IHS) provides comprehensive health services for American Indian and Alaska Native people, with opportunity for maximum tribal involvement in developing and managing programs to improve health status and overall quality of life.

National Institutes of Health (NIH), through its 25 institutes, centers, and divisions, supports and conducts medical research, domestically and abroad, into the causes and prevention of diseases and promotes the acquisition and dissemination of medical knowledge to health professionals and the public.

Program Support Center (PSC) provides a broad range of administrative services to HHS components and other Federal agencies on a competitive, fee-for-service basis. PSC services are provided in three business areas: human resources, financial management, and administrative operations.

Substance Abuse and Mental Health Services Administration, (SAMHSA) through its three centers, works to improve quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illness, including co-occurring disorders, in order to improve health and reduce illness, death, disability, and cost to society.

Assistant Secretary for Management and Budget (ASMB) advises the Secretary on all aspects of administration and financial management, and provides general oversight and direction of the administrative and financial organizations and activities of the Department.

Assistant Secretary for Planning and Evaluation (ASPE) provides policy analysis and advice; guides the formulation of legislation; coordinates strategic and implementation planning; conducts regulatory analysis and reviews regulations; oversees the planning of evaluation, non-biomedical research, and major statistical activities; and administers evaluation, data collection, and research projects that provide information needed for HHS policy development.

Office for Civil Rights (OCR) promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination. Through prevention and elimination of unlawful discrimination, the Office for Civil Rights helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

Office of Inspector General (OIG) improves HHS programs and operations and protects th+em against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations OIG provides timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public.

Office of Public Health and Science (OPHS) provides senior professional leadership across HHS on population-based public health and clinical preventive services by providing scientifically sound advice on health and health policy to the Secretary, Departmental officials and other governmental entities and communicating on health issues directly to the American public; conducting essential public health activities through eleven program offices, and providing professional leadership on cross-cutting Departmental public health and science initiatives.

HHS provides leadership in the administration of programs to improve the health and well-being of Americans, and to maintain the United States as a world leader in biomedical and public health sciences. The programs of the Department impact all Americans, either through direct services, the benefits of advances in science, or information that helps them choose medical care, medicine, or even food. Through Medicare and Medicaid, for example, HHS oversees the administration of the nation's largest health insurance programs, serving an estimated 72 million Americans. Through numerous grants and other financial arrangements with public and private service providers, HHS is committed to improve health and human service outcomes and the economic independence of individuals and families throughout the US.

HHS FY 2000 BUDGET PRIORITIES AND THE HHS STRATEGIC PLAN

For the past several years, HHS has formulated its budget request around priorities that will allow the Department to respond to important national needs. Together with the HHS Strategic Plan, the HHS budget priorities for FY 2000 and previous years define how HHS and its program performance partners will proceed to achieve the mission of the Department and the vision of the President as we approach the twenty-first century.

Unlike many other federal Departments, the Department of Health and Human Services is a large, complex organization that is responsible for implementation of more than 300 programs. Its complexity is reflected in the budget process itself – four separate appropriations subcommittees have responsibility for the budget in the House of Representatives and four in the Senate. Four Senate committees have authorizing responsibility for the Department's programs and five House committees are charged with that task. In addition, three divisions within OMB contribute through the review of the Department's budget. As a result, it is not surprising that the Department has submitted separate Performance Plans for its program components that are attached to these budget documents.

While the budget is considered in a decentralized manner, the Department has established a department-wide set of goals and objectives that are expressed in its Strategic Plan and reflect the following six overarching goals that inform the budget process.

★ Reduce the Major Threats to the Health and Productivity of All Americans;

★ Improve the Economic and Social Well-being of Communities, Families, and Individuals in the United States;

★ Improve Access to Health Services and Assure the Integrity of the Nation's Health Entitlement and Safety Net Programs;

★ Improve the Quality of Health Care and Human Services;

★ Improve Public Health Systems; and

★ Strengthen the Nation's Health Sciences Research Enterprise and Enhance Its Productivity.

These goals have provided the context for requests for budget increases and new program directions for the Department, reflecting both the President's and the Secretary's priorities. As indicated in the analysis that follows, there is a direct relationship between the initiatives found in the budget request and the goals and objectives of the HHS Strategic Plan. Specific strategies related to these initiatives are included under the appropriate Strategic Objective in Section II of this document.

Administration Initiatives

Initiative: ***Supporting Retirement with Dignity***

Over five million Americans have significant limitations due to illness or disability and thus require long term care. Of this total, two-thirds are older Americans. Compounding this problem is the fact that half of all caregivers themselves are older than 65 years and are thus vulnerable to a decline in their own health status. The aging of Americans – where the number of Americans older than 65 years will double by the year 2030 – increases the urgency for quality long-term care options.

This is a multi-part initiative that addresses the daily needs of our Nation's steadily growing elderly population by assisting direct caregivers, educating the elderly and people with disabilities about long-term care issues and options, and promoting new promising strategies for long-term care policy. In addition, it allows Americans between the ages of 62 and 65 to buy into Medicare.

This initiative launches a National Family Caregiver Support Program which provides a range of critical services for caregivers such as respite, home health services, and information and referral. In addition, it calls for a national campaign educating Medicare beneficiaries about the programs' limited coverage as well as an effort that provides citizens with better information on nursing homes. It also advances opportunities for people with disabilities to return to work.

This initiative primarily supports HHS's efforts to achieve Goal 2 of the HHS Strategic Plan – Improve the Economic and Social Well-Being of Individuals, Families and Communities in the United States. Specifically, it enhances the achievement of Objective 2.6 – Expand Access to Consumer-Directed, Home and Community-Based Long-Term Care and Health Services. Programs supported through this initiative are found in HCFA and in the Administration on Aging.

Initiative: ***Improving Quality and Affordable Health Care***

This initiative includes a number of different program areas that expand access to health care for vulnerable groups such as children, pregnant women, the disabled, and displaced workers. It provides funds for new health insurance options for displaced workers, expands opportunities for people with disabilities to return to work without losing their health care, increases access to AIDs therapies, and provides critical mental health prevention and treatment programs. In addition it seeks to expand efforts to reduce racial disparities in health status, provides quality care to native Americans, curtails violence against women, and promotes family planning services.

There are a number of vulnerable populations in the US who experience special health problems. This initiative includes targeting of several of these groups: persons with mental illness who are homeless, individuals with AIDS, women who experience violence, individuals who experience racial disparities in health status, uninsured individuals, and Native Americans. The initiative builds on existing programs targeted at these groups and establishes new or additional efforts.

For example, the initiative calls for an increase in Ryan White treatment grants to help States provide AIDS treatment, especially the promising "combination therapy." It also builds on past efforts designed to assist the over 5 million American women who experience domestic or sexual violence each year. Efforts to prevent and end this violence started as grass-roots, community-based movements more than 20 years ago.

In FY 1999, the President committed to improving the health of *all* Americans. During the past year, a national initiative was begun with the goal of eliminating the historical racial and ethnic disparities in health status by 2010. Achieving this goal requires a substantial long-term commitment to address the fundamental lack of infrastructure and data systems.

Another vulnerable group – Indian people in the US – has the Nation's worst health statistics and the Federal government has a special responsibility to address this problem. This administration has sent representatives to listen to leaders of Indian people but we now require resources that allow us to act in partnership with Indian people.

This initiative supports several of the goals included in the HHS Strategic Plan. Many of the efforts relate to Goal 4 of the HHS Strategic Plan – Improve the Quality of Health Care and Human Services, specifically the achievement of Objective 4.2 – Reduce Disparities in the Receipt of Quality Health Care Services. It also supports Goal 1 of the HHS Strategic Plan – Reduce the Major Threats to the Health and Productivity of All Americans and Goal 3 – Improve the Economic and Social Well-Being of Individuals, Families and Communities in the United States. It will enhance the achievement of Objective 3.6 – Improve the Health Status of American Indians and Alaska Natives – and Objective 4.2 – Reduce Disparities in the Receipt of Quality Health Care Services. Programs included in this initiative are found in ACF, CDC, SAMHSA, HRSA, and IHS.

Initiative: ***Working for a Safe and Healthy Childhood***

A number of efforts within the Department comprise this initiative. It includes assuring that affordable, quality child care for low-income working parents is available; outreach in CHIP and Medicaid; curtailing youth smoking; promoting childhood immunizations; advancing innovative treatments for asthma; supporting graduate medical education at children's hospitals; providing transitional support for youths in foster care; and enhancing Head Start.

The initiative renews measures to combat smoking among young people and builds on gains made in the 1998 State Attorneys General Tobacco settlement. It also focuses on the number of Americans afflicted with asthma which has doubled to total about 15 million people, with the increase in rates in children under 5 years old. The initiative establishes demonstration grants to States for testing innovative asthma disease management techniques for children enrolled in Medicaid.

In addition, it builds on the child care foundation begun by welfare reform and proposes to help working families access and pay for child care. The President has made a long-standing commitment to serve one million children with Head Start services by 2002. The Head Start Reauthorization Act – a piece of bipartisan legislation – strengthened America's premier early childhood development program and ensured that low-income children start school ready to learn.

This initiative supports HHS's efforts to achieve Goals 2, 3 and 4 of the HHS Strategic Plan. Goal 2 of the HHS Strategic Plan seeks to Improve the Economic and Social Well-Being of Individuals, Families and Communities in the United States. Specifically, the initiative is important to the achievement of Objective 2.3 – Improve the Health Development and Learning Readiness of Preschool Children. It supports HHS's efforts to achieve Goal 3 of the HHS Strategic Plan – Improve Access to Health Services and Assure the Integrity of the Nation's Health Entitlement and Safety Net Programs. It also supports Goal 4 of the HHS Strategic Plan – Improve the Quality of Health Care and Human Services. It is important to the success of Objective 4.1 – Promote the Appropriate Use of Effective Health Services. Programs that will be enhanced by the initiative in support of the long-term goals and objectives are found in ACF, AHCPR, CDC, FDA, HCFA, HRSA, IHS and NIH.

Initiative: ***Safeguarding Public Health and Promoting Science and Research***

This initiative reinforces a government-wide commitment to ensure adequate protection of public health and promote scientific expertise. This will be done in several ways. It will include an expansion of resources available to the FDA to comply with the Nation's drug, food and medical device laws and improve the Nation's adverse event reporting system. It enhances food safety and disease surveillance, and expands medical and health care quality research.

For example, medical research in the US is on the brink of unprecedented breakthroughs. Discoveries that improve human health have been growing exponentially and investment during these momentous times have been made to maintain the pace of scientific discovery and to narrow the gap between science and health care.

As global threats to peace persist, terrorism in America has become a very real threat. Bioterrorism is probably the most pernicious because it can affect a large population, remain

undetected for some time, and cause secondary illness or death if the agent is communicable. HHS is the sole Federal agency charged with the responsibility to prepare for and respond to the medical and public health consequences of a bioterrorist event. Our need for building surveillance and laboratory capacity to competently and professionally manage a biological attack is urgent and of utmost importance.

This initiative supports HHS's efforts to achieve both Goal 5 and Goal 6 of the HHS Strategic Plan. Goal 5 calls on the Department to Improve Public Systems and Goal 6 highlights the goal to Strengthen the Nation's Health Sciences Research Enterprise and Enhance its Productivity. It includes programs within NIH as well as AHCPR. Specifically, it is directly related to Objective 5.1 – Improve the Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population. Among the programs that support the achievement of this objective are CDC efforts to develop a public health response to terrorism as well as efforts in the Office of Emergency Preparedness of OPHS and in FDA. It will enhance a wide range of programs within the Department such as information and surveillance programs in CDC, communications programs in FDA, research programs in NIH and AHCPR.

Initiative: ***Improving Fiscal Soundness and Management***

This initiative highlights management issues involving HCFA management; combating Medicare and Medicaid fraud, abuse, and waste; ensuring Y2K compliance; and focusing on the GPRA process. The conversion of computer systems for the year 2000 is one of the most complex tasks that government has ever faced. HHS agencies require an investment in funds and flexibility to respond quickly to unanticipated Y2K conversion problems. In particular, the successful operation of Medicare and Medicaid systems depends on millions of changes made to information systems nationwide.

During the past two years, HCFA has been given additional responsibilities under several new pieces of legislation. These new responsibilities require the agency to develop administrative activities that are costly. These include survey and certification responsibilities in nursing homes as well as collection of overpayments from providers. The HHS initiative not only involves requests for budget increases in the HCFA Program Management account but also requests flexibility in these activities.

This initiative supports HHS's efforts to achieve Objective 3.5 – Enhance the Fiscal Integrity of HCFA Programs and Ensure the Best Value Health Care for Beneficiaries and to address important issues raised in the Management Challenges section of the Strategic Plan, which highlights high-priority initiatives that link activities across the Department's operating divisions as well as program specific efforts.

HHS STRATEGIC PLAN: A POLICY BASE FOR COMPATIBLE CROSS-CUTTING GOALS

The HHS Strategic Plan provides a substantive framework for setting performance goals and measures for the wide array of HHS programs covered by the FY 2000 annual performance plans of HHS components. Section II of this summary, *FY 2000 Performance Activities, Goals and Measures That Support the Achievement of the Strategic Objectives in the HHS Strategic Plan*, serves HHS as a resource for the identification and achievement of cross-cutting goals and objectives for programs administered by the Department, and is the primary data base supporting the illustrative analysis that follows. At the broadest levels of achievement, the goals and objectives of the strategic plan are cross-cutting and substantively supported by the array of program activities and detailed performance goals addressed in the performance plans of HHS and the President's Budget for this Department.

Many of the programs administered by HHS involve goals and objectives that are shared by other programs within the Department and by other agencies and departments within the Federal government. Superficially, the overlap between these programs could be viewed as being duplicative and redundant with one another. This could lead to a view that the program designs are inefficient and could be "neatened" up.

Yet on closer analysis, it becomes clear that these programs are quite different from one another. They often involve a range of interventions that are dissimilar and represent complementary – rather than duplicative – approaches. In some cases, the programs differ from one another because of uncertainty about what will work. In such cases, the range of interventions represent natural experiments and provide information to the society about the most effective approach.

The following 12 examples of cross-cutting strategic objectives illustrate this situation.

★ *Goal l: Reduce the Major Threats to the Health and Productivity of all Americans*

1.1 <u>Reduce Tobacco Use, Especially Among Youth</u>

A number of programs and agencies within HHS are involved in addressing this objective. These include CDC, FDA, IHS, HRSA, NIH, OPHS, and SAMHSA. Some of the programs focus on the development of state-based infrastructures. For example, CDC's Heart Disease and Health Promotion program provides funds to prevent tobacco use. SAMHSA is charged with implementing the Synar Amendment, providing funds to states to support programs for compliance to reduce the sale of tobacco to minors.

FDA efforts emphasize its regulatory role and aims to increase the number of compliance checks performed at retail shops to enforce the requirement that children and teenagers do not purchase tobacco products. NIH's National Institute on Drug Abuse is supporting basic research on nicotine addiction and treatments. Broad gauged education efforts are supported by OPHS through its work with Smoke-Free Kids, US Soccer, and other community coalitions.

Other parts of the Department focus on specific populations. The IHS highlights efforts for community-based prevention activities in AI/AN youth. The Office on Women's Health in OPHS has worked with girls and young women to link their eating disorders initiative to tobacco use prevention. HRSA has targeted Primary Care efforts to reduce racial disparities in tobacco use.

1.2 Reduce the Number and Impact of Injuries

Injuries are one of the leading causes of death and disability in the US and take place in many settings and impose many different kinds of costs (e.g. work loss, health costs, and disability). Thus it is not surprising that activities related to injuries take place in a number of programs within HHS. These include ACF, CDC, HRSA, IHS, and OPHS.

Injury prevention efforts are supported by CDC, working with state and local agencies and evaluating some intervention programs. CDC's fire-related prevention programs involve collaboration with the Consumer Product Safety Commission as well as other Federal and voluntary organizations and its efforts involving bicycle helmet usage (along with the National Highway Traffic Safety Administration) also involve other organizations. In addition, efforts focused on traumatic brain injury highlight prevention activities in both CDC and HRSA, with CDC working with state health departments and HRSA administering a demonstration grant program at the service delivery level.

Several programs focus on the injuries that take place as a result of family violence. ACF is supporting improvements in data collection, monitoring and evaluation to strengthen collaboration between domestic violence services and other service networks. CDC's intimate partner violence program seeks to determine the effectiveness of a number of prevention and intervention programs. OPHS's new Office on Domestic Violence is providing department-wide coordination and leadership on domestic violence.

HRSA's programs of Emergency Medical Services for Children and trauma care are designed to ensure that individuals of all ages can receive appropriate care in a health emergency. It also plans to assist poison control centers with the development of patient care guidelines. IHS collaborates with tribes and others to reduce the incidence of severe injuries. Research activities involving occupational safety and health are conducted by the National Institute for Occupational Safety and Health in CDC.

1.5 Reduce the Illicit Use of Drugs

Drug abuse problems receive resources and attention from a wide variety of Federal agencies. In addition to efforts in HHS (involving IHS, NIH, OPHS, and SAMHSA), the government-wide effort includes the Departments of Justice, Defense, Education and Treasury. This effort is coordinated by the White House National Office of Drug Control Policy. The goals and objectives included in the HHS performance plan have been closely linked to those of other agencies through the ONDCP's document, Performance Measures of Effectiveness: A System for Assessing the Performance of the National Drug Control Strategy.

Several HHS programs focus on prevention activities. SAMHSA's Substance Abuse Prevention and Treatment block grant provides funds to states to support their prevention programs for both adults and children. Other prevention activities include IHS efforts aimed at the AI/AN populations and activities sponsored by the Office on Women's Health. OPHS has supported efforts to work with community coalitions and others. SAMHSA projects attempt to transfer knowledge from prevention studies to practice. Other efforts highlight research activities, particularly the programs of the National Institute on Drug Abuse of NIH.

★ ***Goal 2: Improve the Economic and Social Well-Being of Individuals, Families and Communities in the United States***

2.3 Improve the Healthy Development and Learning Readiness of Preschool Children

During the past few years, research on brain development has helped us understand the relationship between emotional, social and cognitive development of children. These elements are related to the ability of children to perform effectively in school settings. This research serves as one for several interventions supported by the Department in ACF, CDC, HCFA, and HRSA.

The Head Start program, directly implemented by ACF, is one of the major activities that can profit from this research. ACF's implementation of that program provides the route for this, working with community-level partners to create efforts that cut across programmatic lines. While ACF provides child care assistance to low-income families through grants to states, it does not directly deliver Child Care Services. However, ACF can encourage its state grantees to work closely with Head Start and others focused on improvement of that service sector.

The health care focus on these issues is provided by the National Immunization Program at CDC, an effort that supports state and local agencies to improve immunization. CDC strategies serve as the basis for HCFA's requirement that states provide immunization services for eligible children through its Medicaid and Children's Health Insurance Program. HCFA also supports efforts to improve the targeting and enrolling of eligible children in the states.

Still other health programs are supported through the MCH Block Grant program and through the Healthy Start effort, a demonstration effort that targets communities with high rates of infant mortality and other socioeconomic risk factors.

2.5 Increase Opportunities for Seniors to Have an Active and Healthy Aging Experience

The lengthening of the life span in the US has made it essential that we think about ways that older people can maintain productive lives. Programs that are found in AHCPR, AoA, CDC, HCFA, NIH, and OPHS are directed toward this objective.

HHS efforts support several service areas; these include AoA's senior centers, food programs, and transportation services. Funds are provided to state agencies that administer such programs. Health services to older people are supported by CDC's National Immunization Program and by HCFA's Medicare Program. Particular attention is given to several target populations through AoA's grants to Indian Tribes, HCFA's focus on low-income individuals eligible for Medicare, and efforts supported by OPHS's Office on Women Health.

Attention to the impact of the changing structure of the health care system on older citizens is given by HCFA in its efforts to ensure that all Medicare beneficiaries have a choice of health care options. AHCPR is supporting efforts to assess the quality of care given to elderly populations, particularly those in long-term care settings. Research on the goal of keeping people independent, active and productive in later years is conducted by NIH's Roybal Centers of Research on Applied Gerontology.

★ *Goal 3: Improve Access to Health Services and Assure the Integrity of the Nation's Health Entitlement and Safety Net Programs*

3.2 Increase the Availability of Primary Health Care Services

The role of the Federal government in the primary health care area is not to provide a wide range of services to the general population but to target specific services to particular groups, focusing on the supply of services, staffing availability, and working with others to anticipate changes in the way that services are delivered. HHS programs focused on this objective are found in AHCPR, CDC, ASPE, HCFA, HRSA, IHS, OCR, OPHS, and SAMHSA.

Several programs target services on specific populations and emphasize the Federal government's role as providing a safety net for underserved individuals. These include HCFA's efforts involving child health; the range of HRSA programs dealing with issues of access, racial disparities, and rural services; IHS efforts, activities in the Office of Civil Rights dealing with discrimination prevention in access to services, and efforts in OPHS focusing on minority health issues as well as women's health. Concern about the availability of health professionals in underserved areas is emphasized in HRSA's Health Professions and Nursing Training Programs.

Some programs focus on specific health services; SAMHSA's Starting Early, Starting Smart in School program seeks to integrate behavioral health services in school systems, both HCFA and CDC have undertaken efforts related to immunization, and HRSA has emphasized services available through its newborn hearing screening, the MCH block grant as well as its efforts dealing with emergency medical services.

HHS has also undertaken a number of activities that deal with changes in the health care system. These include AHCPR's initiatives to test the effectiveness of health care improvement approaches, HCFA's efforts to collaborate with Peer Review Organizations, and telehealth efforts in HRSA involving both urban and rural communities.

3.3 Improve Access to and the Effectiveness of Health Care Services for Persons with Specific Health Care Needs

Changes in the US society have generated new demands and needs for services. Efforts in the Department highlight problems of specific populations, methods to assess the effectiveness of programs, and the need to establish coordinating or oversight roles within HHS. Activities related to this objective are found in ACF, AHCPR, CDC, HRSA, OCR, OPHS, and SAMHSA.

Concern about access to services is found in the various HIV programs administered by HRSA; ACF's Developmental Disability program; CDC's efforts to improve the prevention, diagnosis and treatment of tuberculosis; and MCH's concern about service needs for children with multiple problems. HRSA's involvement in organ procurement and bone marrow donors represents emerging issues. Similarly, new emphasis has been placed within SAMHSA on the need to address the treatment gap for substance abuse victims as well as the need for community-based services for children with serious emotional disturbances.

Other efforts within the Department have sought to assess the effectiveness of programs (such as AHCPR's concern about improving outcomes for the chronically ill and elderly, children, and women). The Office of the Surgeon General and OPHS have sought to play a coordinating role involving some of these issues and OCR's compliance activities focus on preventing discrimination in access to HHS services.

★ *Goal 4: Improve Health Care and Human Services*

4.1 Improve the Appropriate Use of Effective Health Care Services

Despite the increase in information about health care effectiveness, many of the treatment protocols that are known to be effective and appropriate do not move into common practice. Various parts of the Department are involved in programs that move toward this objective, including CDC, HCFA, OPHS, and SAMHSA.

Several HHS components focus on techniques that seek to translate research into practice. CDC has focused on diabetes control programs as well as more general efforts that produce publications and support training. AHCPR has developed evaluation efforts that examine the interim outcomes of research and SAMHSA's Knowledge Development and Application programs seek to synthesize knowledge in mental health and substance abuse into forms that are useful to practitioners.

HCFA has emphasized the appropriate use of effective medical services by Medicare beneficiaries, particularly involving heart attacks, adult vaccines, and use of mammograms. HCFA has also

recognized the importance of providing child immunization through the Children's Health Insurance Program.

4.2 Reduce Disparities in the Receipt of Quality Health Care Services

HHS has been concerned about the health care disparities across different groups in the society that result from financial status, geography, culture, race and other factors. Programs found within AHCPR, CDC, HCFA, HRSA, IHS, OCR, and OPHS seek to reduce these disparities.

Several agencies have undertaken efforts that focus on disparities in treatment of specific diseases. CDC's efforts include attention to infectious diseases. HRSA's programs relate to a wide variety of diseases, emphasizing both issues of access to treatment as well as racial disparities. These involve infant mortality and other programs for children, availability of organ donations, and a range of efforts involving HIV and AIDS. In addition, HRSA's Health Centers and National Health Service Corps emphasize preventive services to a large minority and low income population and its Rural Health Outreach Grants support services to Americans who live in underserved rural areas. IHS is targeting particular segments of its population (children and youth, women, elders and urban Indians) who are particularly vulnerable. OCR seeks to ensure that there is nondiscriminatory access to HHS services.

CDC has given attention to the role of health care infrastructures in this area, particularly the availability of state-based surveillance systems on injuries that provide information disaggregated by race and ethnicity. OPHS is also collecting and establishing baseline and comparison data for the incidence of a number of illnesses by race and ethnicity. Both AHCPR and OPHS have focused research efforts on projects to address eliminating disparities in health care

4.4 Improve Consumer Protection

The dramatic changes that have taken place in the health care system have made it more important than ever that consumers have adequate information that allows them to make choices about health care plans. Efforts involving the protection of consumer rights, education, research and assuring the accuracy of services have been undertaken by ACF, AoA, ASPE, HCFA, and OCR.

Protection of consumer rights is found in ACF's Developmental Disabilities program, AoA's Long-Term Care Ombudsman program, and the appeals process within Medicare. HCFA has sponsored projects dealing with removal of restraints in nursing homes, and ASPE is undertaking research in this area. OCR seeks to ensure that here is nondiscrimination in the expenditure of Federal funds. Various methods of assuring attention to the accuracy of diagnostic laboratory tests have been supported by HCFA.

★ ***Goal 5: Improve Public Health Systems***

5.1 Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to Health of the Nation's Population

Many of the programs within HHS are focused on the monitoring, surveillance and assessment of health programs. These range from the recent concern with the public health response to terrorism to the historical concern about infectious diseases. Programs are found within AHCPR, CDC, FDA, IHS, NIH, OPHS, and SAMHSA that focus on this objective.

Programs that focus on terrorism issues are found within CDC, particularly through its efforts to build a surveillance and an early warning system, and through the Office of Emergency Preparedness in OPHS which is beginning to stockpile products to respond to biological terrorism.

On-going data systems are an important part of this objective and are found in programs of AHCPR (the Medical Expenditure Panel Survey and the Healthcare Cost and Utilization Project), CDC's efforts involving general health statistics, cancer and infectious diseases, and SAMHSA's data infrastructure initiative. FDA's Food Safety Initiative creates a system that will provide information on outbreaks of foodborne illnesses. In addition to data concerns, other infrastructure development programs involve CDC's Chronic Disease Initiative (particularly asthma) and IHS's Treatment Epidemiology Centers.

★ ***Goal 6: Strengthen the Nation's Health Sciences Research Enterprise and Enhance its Productivity***

6.2 Improve the Prevention, Diagnosis and Treatment of Disease and Disability

While the Department supports many research efforts, it does so believing that there is a direct relationship between knowledge acquired by research and the ability to improve the range of interventions in the health and human services systems. This objective serves as the underpinning for programs found in AHCPR, CDC, NIH and SAMHSA.

The basic and applied research that is supported by NIH highlights several aspects of this objective. The NIH centers seek to develop new and improved approaches for preventing or delaying the onset of disease and disability. They also seek to improve and develop new methods for diagnosing disease and disability. One of the most visible expressions of this approach is found in NIH's efforts to develop an AIDS vaccine.

In addition, CDC efforts are aimed at the support of a bridge between research and public health practice. AHCPR's programs highlight the implementation of evidence-based information in different health care settings and emphasize approaches to improve clinical practice. SAMHSA's Knowledge Development and Application efforts in both mental health and substance abuse attempt to support the translation of research and demonstration findings to practice.

FY 2000 PERFORMANCE PLANS AND DEPARTMENTAL COMMITMENT TO MANAGEMENT IMPROVEMENT

Both the long-term strategic and annual goals and performance measures of HHS focus primarily on the ***program outcomes and results*** that we and our program partners work to achieve through the many health and human service programs administered by the Department. At the same time, improvement in the management of this large, decentralized agency also continues to be a Department priority. Therefore, the measurement of performance for both ongoing management activities and management improvement initiatives is a significant aspect of HHS' annual performance plans. The Department is now much leaner and more efficient as a result of actions to streamline the management structure of HHS and devolve significant management authority to program managers. While recognizing that these actions have significantly improved management in the agency, more can be accomplished.

National Partnership for Reinventing Government

HHS efforts to improve accountability and performance measurement in management follow from the challenges that have been set for Federal executives, managers and employees through the National Partnership for Reinventing Government (NPR). The NPR has designated three HHS operating divisions as High Impact Agencies, including: the Administration for Children and Families, the Food and Drug Administration, and the Health Care Financing Administration. The "high-impact" goals of these agencies have been incorporated directly into the FY 2000 annual performance plans of the agencies.

Internal Financial Management Performance Measurement

The Department's FY 1998 Financial Management Status Report and Five-Year Plan includes over one hundred separate performance measures for internal tracking of management improvements throughout the Department. The plan is structured around two financial management strategic goals:

- ***Decision-makers must have timely, accurate, and useful program and financial information; and***
- ***All resources are used appropriately, efficiently, and effectively.***

These goals provide the framework for specified improvements across the Department in the following financial management areas:

- Obtaining unqualified opinions on financial statements;
- Improving, enhancing, and integrating financial management;
- Improving budget formulation;
- Strengthening business practices;
- Improving physical asset management;
- Strengthening internal controls; and
- Developing and retaining highly skilled, strongly motivated financial management staff.

Major HHS-Wide Management Improvement Goals

HHS initiatives for improvement of management functions are consistent with those that have been developed for the Federal Government as a whole and implemented on a Departmental basis. Even though the performance plans for the programs of HHS components are separate submissions, major critical management goals and objectives apply Department-wide and will be assessed on that basis. Significant Departmental management goals are presented in the performance plan and budget for the Office of the Secretary. The following are examples of FY 2000 performance information for selected major management initiatives for HHS.

Year 2000 Problem

To prevent any failures of critical program systems resulting from the "Year 2000" problem, Y2K compliance for information systems is a top Department priority. HHS FY 2000 performance objectives and measures state:

- ***100% of HHS information systems will function properly into the Year 2000.***

- ***Business continuity and contingency plans will be available for 100% of critical business processes and mission-critical systems.***

Financial Statements

Improved assurance of integrity in the financing of Federal programs and the presentation of accurate and timely cost information are critical priorities for all Federal agencies. Among the HHS FY 2000 performance objectives and measures for this activity are:

- ***HHS and its operating divisions will receive unqualified opinions in their FY 2000 financial statement audits***

- ***The number of material weaknesses identified in financial statement audits will be reduced from 22 in FY 1997 to 3 in FY 2000***

- ***All HHS operating divisions will be in substantial compliance with the requirements of the Federal Financial Management Improvement Act***

Debt Collection

HHS has taken advantage of the tools provided by the Debt Collection Improvement Act to improve collections and reduce outstanding debt to the Department. Reflecting commitment to ongoing improvement in debt collection, HHS FY 2000 performance objectives state:

- ***HHS's FY 2000 debt collections will be 10% higher than those for FY 1999***

Acquisition Reform

Utilization of performance-based service contracting (PBSC) in HHS has led to early improvements in the procurement system, including the identification of specific contracts with strong potential for conversion and the conduct of PBSC training. HHS FY 2000 performance objectives state:

- ***100% of service act contracts will be designated for conversion to PBSC in FY 2000 and significant numbers of non-service act contracts will be targeted for conversion in successive fiscal years.***

Electronic Commerce

Taking advantage of technology for financial transactions reduces the costs associated with payment and increases control in financial management. It reduces paperwork burden and facilitates the reconciliation process. HHS continues to pursue maximum utilization of electronic media for financial transactions. HHS FY 2000 performance objectives state:

- **100% of fund transfers for grants, salaries, vendors, and travel will be made electronically by the end of FY 2000.**

Human Services Management

Effective and efficient use of human resources requires collaborative efforts between HHS management and its labor unions. This form of collaboration provides a setting that will improve workplace relationships and the quality of worklife. HHS FY 2000 performance objectives state:

- **HHS, all OPDIVs, and 70% of bargaining units will have functioning labor-management partnerships by the end of FY 2000.**

Major Program Management Initiatives and Performance Measures

Not all significant management priorities and initiatives apply across the board to all operating components of the Department. A number of management initiatives that apply to specific HHS components are also major Departmental priorities because of their impact on HHS programs and the people we serve. What is common to these initiatives and major Departmental management activities is that HHS pursues performance measurement for them in the FY 2000 performance plans.

A CRITICAL CHALLENGE: MEASURING PROGRAM RESULTS WITH COST-EFFECTIVE, HIGH-QUALITY DATA

Introduction

The range, complexity and diversity of programs implemented by the Department have contributed to one of the most critical challenges in the implementation of GPRA within HHS – the data issue. The absence of timely, reliable, and appropriate data is often a limiting factor in developing performance goals, objectives, and measures for HHS programs. Many of the Department's critical challenges in obtaining high-quality, cost-effective data for setting program goals and measuring program performance under GPRA are related to programs that are implemented in partnership with States, localities and other implementation partners.

The range of participants as well as the diversity of HHS programs means that there are not comprehensive or final solutions to the performance measurement data challenges confronted by the Department. HHS confronts serious data issues related to: the range of data sources; the complexity of data systems; problems achieving agreement by program partners; the timeliness of data; lack of agreement on program aspects; variability in technical ability; chronic lack of resources; and problems of verifying and validating data.

The Department is not without information resources for measuring performance. HHS has a large number of administrative and survey data systems to draw upon. In order to obtain data on outcome measures, for example, the Department relies upon major national surveys such as the National Health Interview Survey, the National Household Survey on Drug Use, the Behavioral Risk Factor Surveillance System and many others. And in order to obtain data on process measures (i.e., services provided to clients) and capacity measures (i.e., activities designed to improve program quality), the Department depends on an even larger number of administrative data systems. Although these data sources were originally developed for other management and research purposes, many are relied on to support performance measurement functions.

While data issues often act as constraints on HHS program units, there have been some creative efforts within the Department to meet the data challenge. For example, the Maternal and Child Health Program has been able to achieve agreement from its state partners to identify a set of performance measures that will be used in state applications for the MCH block grant that are reported through an electronic reporting system. This was achieved over a multi-year process that began with work with a number of pilot states. HHS has also organized a Data Council that plays a role in a number of areas, particularly in the development of Department-wide data collection, including coordination and consolidation of surveys. Venues such as the Data Council provide a setting for program units to share experience and information that will assist others address the data issues.

While the Department is aware of the parameters of the "ideal"data system, application of these requirements across data sets and sources is complicated and requires a case-by-case evaluation of data sources. The Department strives for systems that include standard (or at least compatible) definitions across Federal agencies, participating jurisdictions and time periods; application of statistical standards for accuracy, completeness and reliability; data collection that is timely and

collected at appropriate periodicity; State and/or local estimates if the outcome, process and capacity measures are expected to monitor the performance of states and/or localities; and validation of data on a regular basis.

Summary of Data Issues

Diversity of data sources. The data that are being used by HHS programs in the GPRA process have been drawn from many different sources and reflect very different agendas for information collection and analysis. Some of the data are produced as a result of internal tracking for management purposes; this type of data often focuses on program outputs and was originally designed to provide information to program managers for internal control purposes. Other data that have been included in the performance plans were collected as a part of evaluation activities; both AoA and FDA have utilized this information form. Still other programs have used customer satisfaction surveys and household surveys to establish measures of performance. In a few instances, programs have utilized non-governmental data sources to assess achievement, relying on the validity of those sources. While programs may use these multiple data sources, program managers acknowledge that there may be serious, and often unknown, limitations in using these sources to predict and assess program performance and achievement of outcomes.

Complexity of data systems. Several HHS programs have acknowledged that their data systems produce information that may be somewhat misleading in performance assessment. The data that have been available to programs such as AoA and SAMHSA focused on counting service units, not on the number of individuals served. As a result, this data often include duplicated counts of cases or individuals, which limit the usefulness of the data for performance measurement. Although attempts are being made to "clean up" such data and produce unduplicated counts, that process is a lengthy one. Similarly, other program data, including some collected by IHS, are known to contain some elements of miscoding which can affect the accuracy of program measurement. While the programs seek to verify these data, there are costs to improving this type of precision.

Reliance on achieving agreement by partners. A significant number of HHS programs must rely on data that are collected by the organizations that are involved in the implementation process. Data that emerge from these groups are constrained by the agreement of those partners to the data definitions as well as the burden of collection and reporting. The process of achieving agreement from the Department's intergovernmental partners is often time consuming and requires significant staff investment. State and local governments will sometimes allege that the requirement for such data collection is prohibited by the Unfunded Mandate Act since funds are not always available to these partners to pay for the information collection. At the same time, some states and localities already have performance systems in place. In addition, the policy shift to devolution and contracting out of services complicates what is already a very complex system. For example, the Indian Self Determination Act requires IHS to achieve agreement from its tribal partners in the data collection process. Under these circumstances, it is tricky to establish methods of verifying data, particularly when it may come from proprietary sources.

Timeliness of data. Many of the data sources that have been utilized in the GPRA process contain significant periodicity problems. While appropriate data are collected, they are not collected on an annual basis. In some cases, the data that are required must track special population groups and are not collected regularly. In addition, some aspects of the HHS program portfolio – particularly its research efforts – find it extremely difficult to be held to annual assessments of progress when the outcome cycles have long time frames. Lags in reporting and properly processing data are also a problem, even when data are collected on an annual basis. Data for many HHS goals and measures for individual fiscal years will not be available for several years after the end of those years.

Lack of agreement on program elements. A number of the HHS programs contain elements that are in dispute. For example, drug intervention programs are based on very different approaches to the problem. In such instances, both the general public and the program specialists may disagree about definitions of services and characteristics of program design. Data that are to be collected vary in meaning for these disputed areas. Similarly, some programs are based on intervention strategies that make it difficult to define clear cause-effect relationships and there are competing views about what may cause a desired outcome.

Variability in technical sophistication. The broad array of both governmental and non-governmental partners involved in HHS programs exhibits dramatic variation in terms of their technical ability to deal with data systems and data needs. For example, the problems involved in the Y2K conversion for Medicare contractors in particular, illustrate the variation in ability to respond even to technical automation issues. This is likely to be even more pronounced for data from nonprofit entities under contracts with States or other governmental units for service delivery.

Multiple agencies involved in service delivery. Recent changes in program design and policy directions have indicated that traditional boundary lines between programs are becoming increasingly blurred. Efforts to deal with the "whole person" through various services integration efforts require multiple agencies to cooperate not only in the delivery process but in integrating data needs. Sharing of information across program streams can be achieved, but – like the problems involved in dealing with non-Federal partners – the process is extremely time consuming, and the data are often internally inconsistent. Program units find that they are increasingly dependent on data that are collected by other providers and over which they have little control.

Chronic lack of resources for data collection. It is obvious that data collection is both costly and requires a significant investment in staff resources. Programs that require data collection from non-federal sources often face the question, "who will pay for this effort?" in an environment of fiscal scarcity. In addition, efforts to collect information are hampered by the requirements of the Paperwork Reduction Act. Although we want data, we encounter a number of both fiscal and authority constraints on its collection. SAMHSA has been relatively successful in its efforts to collect performance-related information from States in both the mental health and substance abuse area. But this has been achieved over a multi-year process.

Working with Our Partners on Solutions

The development of a robust system for measuring the performance of HHS' programs is an iterative process that will require continuous review and refinement as the system matures. As we begin to use the data for making program decisions and gain more experience in working with various data systems, current measures may be revised or discarded, and new measures will be developed as replacement measures or to fill gaps in coverage. Much of this work will require the full participation and agreement of HHS' partners in other Federal agencies, the States, and local organizations who participate in the implementation of HHS programs.

To adapt data developed for other purposes to measure program performance, HHS programs and implementation partners are working to resolve differences in: survey definitions used across agencies and across reporting jurisdictions within the same survey; data collection methodology across surveys and/or across jurisdictions, e.g., in-person interviews vs. telephone surveys, sampling frames, and periodicity; reporting periods, especially in the case of national surveys; the time lag between actual data submission and data compilation; and the number of jurisdictions who participate in each of the Department's administrative reporting systems, as well as the various surveys that the Department undertakes in cooperation with states and localities.

HHS programs will need to develop new data systems to supplement currently available data or support more accurate, informative indicators of performance. This will require the Department to assess carefully where to invest new resources, as well as determine what current data collection can be reduced or eliminated in order to free up resources to collect new data. As agencies look to develop new data while reducing less important data collection and reporting requirements, the Department will look for opportunities for sharing data sources where outcomes cut across programs. In searching for additional data relevant to outcomes, agencies will also need to consider using data from non-traditional sources, for example, from other agencies involved in the delivery of similar services, as well as those involved in national surveys.

Several HHS components are exploring opportunities to share existing data and to collaborate on the development of measures where several programs, or funding sources, contribute to common outcomes. HHS has funded a small demonstration and evaluation project to expand on work underway in the ACF Office of Community Services (OCS) on coordinating performance management to achieve community development goals. This project will help OCS address coordination of performance measurement and service delivery at the community level – goals that are important to the Department as a whole. HRSA is also evaluating the potential for collaborating with other Federal, State, and local entities funding and delivering community health services on the development of community level health measures.

HHS components are reviewing and considering incorporating measures developed by States in their performance plans. Doing so requires resolving differences in data collection and reporting vehicles, but in the long run working with available state data may reduce administrative burden and builds credibility and confidence in Federal/state "partnerships."

HHS is committed to working creatively with our Federal, State and local partners to address the challenges we jointly face in measuring performance for health and human service programs.

SECTION II:

FY 2000 PERFORMANCE ACTIVITIES, GOALS AND MEASURES THAT SUPPORT THE ACHIEVEMENT OF THE HHS STRATEGIC PLAN

The HHS Strategic Plan identifies six long-range strategic goals that support HHS' mission to enhance the well-being and health of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services. Each strategic goal is supported by strategic objectives that focus on the strategies that HHS will utilize to achieve the strategic goal. These long-range, strategic goals and objectives serve as the performance management framework of the Department.

To best accommodate the linkage of performance goals and measures for program activities to the budget requests for these programs, HHS incorporated its annual performance goals and measures into the budget submissions for the HHS Operating Divisions that administer the programs. The HHS Operating Divisions' FY 2000 Performance Plans and Budgets, both of which are important to understand performance planning in HHS, contain detailed performance information for HHS' approximately 300 program activities as required under GPRA. They contain performance goals and measures, the means and strategies that will be used to achieve the goals, data verification and validation, linkage to the operating division's budget, and discussions of cross-cutting programs.

HHS Strategic Goals

- ★ Reduce the major threats to the health and productivity of all Americans.
- ★ Improve the economic and social well-being of communities, families, and individuals in the United States.
- ★ Improve access to health services and assure the integrity of the nation's health entitlement and safety net programs.
- ★ Improve the quality of health care and human services.
- ★ Improve public health systems.
- ★ Strengthen the nation's health sciences research enterprise and enhance its

This section of the HHS Performance Plan Summary illustrates how the strategies, goals, and measures in the FY 2000 Performance Plans and Budgets of the HHS Operating Divisions link together to support the achievement of HHS' long-range strategic goals and objectives. For each HHS strategic objective, this section provides key performance strategies for FY 2000, selected FY 2000 goals

and measures that will indicate progress towards achieving the objective, and a list of all HHS programs that support the objective.

The following HHS operating divisions and staff offices within the Office of the Secretary are represented in Section II:

Administration on Aging (AoA) serves as the primary federal focal point and advocacy agent for alder Americans. Through a network of state and area agencies on aging, AoA funded programs deliver comprehensive in-home and community services; and make legal services, counseling, and ombudsmen programs available to elderly Americans

Administration on Children and Families (ACF) leads the nation in improving the economic and social well-being of families, children, and communities though federal grant programs like Head Start, Child Support Enforcement, Child Welfare Services, Child Care and Development, and Temporary Assistance to Needy Families.

Agency for Health Care Policy and Research (AHCPR) supports and conducts health services research and disseminates information to improve clinical care and the organizing and financing of health services; enhance the cost-effective use of health care resources; measures and improve the quality of health care; and enhance access to care.

Centers for Disease Control and Prevention (CDC) monitors health; identifies and investigates public health problems; promotes healthy behaviors; and develops and advocates sound public health policies to prevent and control disease, injury, and disability.

Food and Drug Administration (FDA) promotes improvement in the health of the American public by ensuring the effectiveness and/or safety of drugs, medical devices, biological products, food, and cosmetics; and by encouraging the active participation of business and the public in managing the health hazards associated with these products.

Health Care Financing Administration (HCFA) pays Medicare benefits; provides states with matching funds for medicaid benefits; conducts research, demonstrations, and oversight to ensure the safety and quality of medical services and facilities provided to Medicare beneficiaries; and establishes rules for eligibility and benefit payments.

Health Resources and Services Administration (HRSA) promotes equitable access to comprehensive, quality health care for all, with a particular focus on underserved and vulnerable populations.

Indian Health Service (IHS) provides comprehensive health services for American Indian and Alaska Native people, with opportunity for maximum tribal involvement in developing and managing programs to improve health status and overall quality of life.

National Institutes of Health (NIH), through its 25 institutes, centers, and divisions, supports and conducts medical research, domestically and abroad, into the causes and prevention of diseases and promotes the acquisition and dissemination of medical knowledge to health professionals and the public.

Substance Abuse and Mental Health Services Administration, (SAMHSA) through its three centers, works to improve quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illness, including co-occurring disorders, in order to improve health and reduce illness, death, disability, and cost to society.

Assistant Secretary for Management and Budget (ASMB) advises the Secretary on all aspects of administration and financial management, and provides general oversight and direction of the administrative and financial organizations and activities of the Department.

Assistant Secretary for Planning and Evaluation (ASPE) provides policy analysis and advice; guides the formulation of legislation; coordinates strategic and implementation planning; conducts regulatory analysis and reviews regulations; oversees the planning of evaluation, non-biomedical research, and major statistical activities; and administers evaluation, data collection, and research projects that provide information needed for HHS policy development.

Office for Civil Rights (OCR) promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination. Through prevention and elimination of unlawful discrimination, the Office for Civil Rights helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

Office of Inspector General (OIG) improves HHS programs and operations and protects them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations OIG provides timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public.

Office of Public Health and Science (OPHS) provides senior professional leadership across HHS on population-based public health and clinical preventive services by providing scientifically sound advice on health and health policy to the Secretary, Departmental officials and other governmental entities and communicating on health issues directly to the American public; conducting essential public health activities through eleven program offices, and providing professional leadership on cross-cutting Departmental public health and science initiatives.

HHS Goal 1: REDUCE THE MAJOR THREATS TO THE HEALTH AND PRODUCTIVITY OF ALL AMERICANS

From the HHS Strategic Plan, September 1997. Good health lies at the heart of the nation's well-being. A healthy work force is more productive; a healthy student body is ready to learn; and a healthy people is able to build a better society. Individual behavior, education, equality of opportunity, social and physical surroundings, the economy, and access to health care are all elements crucial to health, and therefore offer opportunities to promote good health.

Research has established that the major behavioral factors contributing to premature death are tobacco, diet and activity patterns, alcohol, injuries, sexual behavior, and illicit drug use. Collectively, these account for 50 percent of all premature deaths each year in the United States. In addition, unintentional injuries, suicides, and homicides account for 30 percent of all years of potential life lost under the age of 65.

Investments in programs that are effective in reducing or eliminating these behavioral threats pay off heavily in improved health and productivity of the American people. The results—better health for individuals and longer life spans—are highly valued by the public. Of the strategies developed by the Department of Health and Human Services (HHS) for reducing behavioral threats to health, most employ a combination of research, prevention, public education, and regulation. All involve multiple components of the Department and rely heavily on partnerships with other levels of government and the private sector, including academic institutions, voluntary associations, and advocacy groups. To reflect our growing understanding of the importance of social and environmental factors for health status, the Department strives to create partnerships with organizations from those sectors. Special efforts are made to target vulnerable populations, including youth, the elderly, women, minorities, and individuals with disabilities. To integrate our activities, the Department has established a conceptual model for the nation—*Healthy People*—that sets an agenda for prevention programs in the public and private sectors and guides our selection of ten-year targets. The objectives and strategies described below, based on research findings and developed in partnership with national health organizations, will contribute to achieving specific Healthy People objectives in the year 2000 and will build a foundation for achieving a new set of Healthy People objectives in the year 2010.

HHS 1.1: Reduce Tobacco Use, Especially Among Youth

From the HHS Strategic Plan, September 1997. Tobacco is the leading cause of avoidable death in the United States, killing a larger number of people than AIDS, automobile collisions, suicides, homicides, fires, and illegal drugs combined. Over 400,000 tobacco-related deaths occur each year from cancer, stroke, cardiovascular disease, lung disease, low birth weight and other problems of infancy associated with maternal smoking during pregnancy; fires; and environmental tobacco smoke. The cost of direct medical care for tobacco-related illness is estimated at $50 billion a year. Research shows that, by reducing the rate of tobacco use, the Department can improve the health and quality of life of the population.

Key FY 2000 Activities, Initiatives, and Strategies

- Administration Initiative – Protecting Children from Tobacco. The FY 2000 budget combats smoking among young people. This budget builds on gains made in the 1998 State Attorneys General Tobacco Settlement and takes significant new steps to defend public health. The HHS FY 2000 budget includes $61 million of additional funds for tobacco related activities. Of this amount, $27 million expands the Centers for Disease Control and Prevention's (CDC's) State-based tobacco prevention activities, and $34 million supports the FDA's outreach and enforcement activities. The Administration again will support legislation which confirms the FDA's authority to regulate tobacco products, to halt advertising targeted at children, and to ensure that cigarettes are not sold to minors.

- FDA – Tobacco. FDA will increase the number of compliance checks performed at retail outlets to ensure that retailers are complying with the rule not to allow children and teenagers to purchase cigarettes and smokeless tobacco products. Full implementation of FDA's rule will eliminate certain forms of advertising that are especially appealing to young people. The outreach efforts will increase the number of retailers who receive information from FDA. This information is targeted to help retailers understand their responsibilities under FDA's tobacco rule and ultimately comply with the requirements that prohibit sales to children and teenagers. FDA also plans to complete the process of classification of tobacco products under the Food Drug and Cosmetic Act; establish requirements under the quality system regulations; and begin ingredient review and new product review.

- SAMHSA – SAMHSA, through its Substance Abuse Prevention and Treatment (SAPT) Block Grant, administers the Synar Amendment which requires State legislative and enforcement efforts to reduce the sale of tobacco products to minors. SAMHSA requires States to enforce their laws and inspect outlets to measure the level of retailer compliance with tobacco sales reduction.

- HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports prenatal care programs that encourage healthy maternal behaviors, including risk reduction behaviors, especially for alcohol, tobacco, and substance abuse.

CDC – Heart Disease and Health Promotion, Preventing Tobacco Use. CDC will expand upon the current infrastructure of state-based tobacco control, by expanding resources available to localities to prevent tobacco use. State-of-the-art training and technical assistance will also be expanded nationwide to further empower local governments, schools, coalitions, and national organizations to develop effective initiatives and programs.

  Progress will be assessed through measurable objectives developed for each activity. Surveillance will enable adequate tracking of smoking initiation as well as smoking prevalence among young people. Evaluation will also include methods to assess effective program policies and interventions that incorporate the learning experiences of states such as California, Massachusetts, Arizona and Oregon. CDC will also undertake critical research efforts, including prevention research and research on the health effects of tobacco additives and smoke constituents.

IHS – Prevention, Health Education. IHS will assist its partners to engage in community-based prevention initiatives, such as HIV/AIDS risk behavior, violence prevention, child abuse, physical inactivity, tobacco, alcohol and substance abuse.

OPHS – To prevent the abuse of tobacco, alcohol and other drugs by youth, OPHS promotes partnerships with parents and other caregivers, teachers, coaches, clergy, health professionals, and business and community leaders. Through the Smoke-Free Kids partnership with US Soccer, OPHS coordinates the dissemination of a national program promoting participation of adolescents in soccer as a way to reduce risk of tobacco use. Also, OPHS assists in the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use, supports and disseminates scientific research and data on the consequences of legalizing drugs, and promotes other similar activities. Girl Power activities work to improve the self esteem of girls and young women so that they adopt healthier lifestyles and reduce their risks for smoking, substance abuse and teen pregnancy.

HRSA – Primary Care, President's Race Initiative. HRSA will reduce racial disparity for patients in communities with the highest morbidity and mortality rates for minority populations. Activities will focus on preventive services and reduction of risk factors contributing to the conditions, including provision of smoking cessation counseling.

NIH – To increase the effectiveness of long term smoking cessation treatments NIH will focus on the development of nicotine and non-nicotine replacement medications in combination with behavioral strategies. For example, the National Institute on Drug Abuse will expand its support for basic research on the basic and pharmacologic basis of nicotine addiction, and continue to support behavioral research on nicotine and smoking and epidemiological studies that monitor patterns of drug use including nicotine.

Selected FY 2000 Performance Goals and Measures

- Reduce the percentage of teenagers (in grades 9 - 12) who smoke from 36.4 % to 21% by 2010 by conducting education campaigns, providing funding and technical assistance to state programs, and working with nongovernmental entities. This would require an annual reduction of 1.2 percentage points (starting in 1997 and ending in FY 2010.) *CDC Plan*

- Reduce the easy access to tobacco products and eliminate the strong appeal of these products to children. FY 2000 measure: Conduct 400,000 compliance checks and select certain sites to target for intensified enforcement efforts to determine the effectiveness of different levels of effort. *FDA Plan*

- By the end of FY 2000, determine Area age-specific prevalence rates for the usage of tobacco products. *IHS Plan*

- Reduce past month use of cigarettes by youth ages 12-17. Baseline will be determined in 1999 and a target will be set for 2000. SAMHSA's national household survey is proposed as the data source. The methodology of the survey is scheduled to change in 1999, hence the need to use that year as the baseline. [Developmental] *OPHS Plan*

Programs Supporting This Objective

CDC
Heart Disease and Health Promotion
FDA
Tobacco
HRSA
Primary Care
Maternal and Child Health Block Grant
IHS
Prevention
NIH
Research Program
OPHS
Healthy People 2000
Office on Women's Health
SAMHSA
Knowledge Development and Application
Targeted Capacity Expansion
High Risk Youth
National Data Collection State Infrastructure
Substance Abuse Block Grant

HHS 1.2: Reduce the Number and Impact of Injuries

From the HHS Strategic Plan, September 1997. Claiming nearly 150,000 lives each year, injury is one of the leading causes of death and disability for all age groups. The impact of injury is especially high for young Americans. Indeed, from the time a child celebrates his 1st birthday until he reaches age 45, injury—unintentional injury, homicide, and suicide combined—will be his or her leading risk of death.

Each year, there are an estimated 37 million injury-related visits to emergency departments. Three-fourths of these visits are associated with unintentional injuries and one-fourth with intentional injuries. The cost of these injuries in direct medical care and rehabilitation, as well as in lost income and productivity, totals an estimated $224 billion a year. Each year, over 11 million persons 12 years of age and older are victims of violent crimes, many of which result in injury. Racial and ethnic minority populations are at highest risk of injuries resulting from violence, thus making prevention of violence a key to improving the health of these communities.

Although great strides have been made in reducing occupational injuries, workplace hazards continue to inflict a tremendous burden on the nation in both human and economic costs. Each day, on average, sixteen people die from work-related traumatic injuries. In 1995, occupational injuries cost $119 billion in lost wages and productivity, administrative expenses, health care, and other costs. Clearly, focusing on the reduction of injuries has a substantial societal benefit.

Key FY 2000 Activities, Initiatives, and Strategies

CDC – Injury Prevention and Control. The National Center for Injury Prevention and Control (NCIPC) works to prevent premature death and disability through: extramural and intramural research, developing, evaluation, and implementing prevention programs, assisting State and local health jurisdictions in their efforts to reduce injuries, and conducting prevention activities in partnership with other Federal and private-sector agencies. Evaluation of intervention programs is a key component of CDC's overall strategy to discover what works and determine how best to deliver programs to the American people. Priority areas for FY 2000 include:

Traumatic Brain Injury (TBI). CDC will continue working toward effective prevention programs for TBI by developing a uniform reporting system; funding research; supporting State health department prevention projects; promoting public awareness of TBI; and evaluating the use of registries to improve the quality of life for persons with TBI.

Youth Violence Prevention. CDC funds projects to evaluate effective interventions for preventing and reducing aggressive behavior among youth. The majority of the projects emphasize primary prevention and are cooperative efforts among schools, health departments and community partners. Several projects have been funded across the country which have looked at a broad range of promising interventions including peer mediation, conflict resolution training, mentoring, role playing, and efforts to improve parenting skills. These

interventions will serve as the framework for developing performance measures aimed at reducing the incidence of youth violence.

Intimate Partner Violence. CDC funds projects to determine how effective specific prevention or intervention programs, or combinations of these programs, are in preventing intimate partner violence and sexual assault. The expansion of this program will broaden the population-base receiving the interventions which will lead to greater knowledge of modifiable risk factors and consequences associated with the development of effective prevention and intervention strategies for intimate partner violence and sexual assault.

Bicycle Helmet Usage and Head Injury Prevention. CDC works to prevent these injuries and deaths by developing and disseminating injury control recommendations on bicycle helmets; collaborating with the National Highway Traffic Safety Administration, other federal agencies, private and voluntary agencies to promote helmet use and bicycle safety; and providing grants to state health departments to implement and evaluate programs that promote helmet use. In 1994, CDC began funding programs to promote helmet use within funded communities.

Fire-Related Injury Prevention. CDC works to prevent these needless deaths by conducting, coordinating, and funding fire and burn prevention research and interventions at the state, local, and community levels, and collaborating with the Consumer Product Safety Commission, U.S. Fire Administration, other federal agencies, private and voluntary agencies on developing recommendations for conducting and evaluating smoke detector programs.

- IHS – Prevention, Injury Prevention. IHS collaborates with tribes and other Federal, State, and local agencies in efforts to reduce the incidence of severe injuries, with special emphasis on primary prevention, developing programs on sound epidemiological bases, and funding community-based prevention projects. IHS has developed injury prevention training programs specifically for the community-based practitioner. IHS will also assist tribes in building their capacity and local tribal health infrastructure to develop effective programs to prevent traumatic injuries and death and increase the number of tribal injury prevention programs by as many as 65 projects.

- FDA – Injury Reporting Initiative. Reduce injuries and illnesses resulting from consumption and use of FDA-regulated products. One of the FDA's primary objectives is to develop and implement a comprehensive surveillance system to improve the quality of information on adverse events and product defects associated with FDA-regulated products. The system will focus on three areas: surveillance and epidemiology; research; and education and outreach. FDA believes this system will increase the safety of FDA-regulated products because more reports of rare and unexpected adverse events and product problems would be discovered and corrective action taken. Systematic feedback about the problem can then be provided to the healthcare community and the public.

- HRSA – Maternal and Child Health, Traumatic Brain Injury Program (TBI). The TBI Demonstration Grant Program is designed to improve health and other services for the assessment and treatment of TBI and to emphasize activities by States that implement State-wide systems that ensure access to comprehensive and coordinated TBI services.

- Administration Initiative – Curtailing Violence Against Women. The FY 2000 budget includes $27 million to curtail violence against women. Specifically, this budget invests in enhancing services and changing social norms. Over 4,200 women are murdered each year by someone they know and intimate partners commit over half of those murders. HHS proposes $23 million to provide counseling and shelter for domestic violence victims and enhance other services, and includes $4 million to improve public education about domestic violence.

- ACF – Family Violence Prevention. In support of the broader Department-wide domestic violence initiative, ACF will support improvements in data collection, monitoring, and evaluation, and technical assistance and demonstration strategies to strengthen collaboration between domestic violence services and other service networks, building on the first steps already taken in child support, child welfare, TANF and criminal justice.

- OPHS – The new Office on Domestic Violence, housed within the Office of Women's Health, will provide HHS-wide coordination and leadership on domestic violence. In addition, it will staff the President's Advisory Council on Domestic Violence and the HHS Steering Committee on Violence Against Women. The Surgeon General will serve as the spokesperson for HHS on domestic violence.

- HRSA – Primary Care, Health Centers. HRSA's Health Centers are implementing a Family Violence Initiative and plan to add parenting classes, home visiting and abuse prevention services in high risk areas.

- HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports injury prevention and domestic violence reduction programs that reduce both accidental and intended injuries, especially to children.

- HRSA – Maternal and Child Health, Poison Control Centers. HRSA will support the development of a series of patient management guidelines for selected poison exposures thus providing consistent, evidence-based protocols nationally and regionally.

- HRSA – Maternal and Child Health, Trauma Care/Emergency Medical Services (EMS). HRSA will work with State emergency medical services directors to follow up on the recommendations of the NHTSA report, with particular focus on assessing EMS capacity within their states.

- HRSA – Maternal and Child Health, Emergency Medical Services for Children (EMSC). EMSC is designed to ensure that all children and adolescents, no matter where they live or where they travel, can receive appropriate care in a health emergency. It seeks to improve all aspects of children's acute emergency medical care, including pre-hospital care, emergency department care, hospital care, and rehabilitation, and to prevent such emergencies from occurring. HRSA will increase systems improvement grants to States in order to fund additional evaluation, data improvement, and evidence-based research.

CDC – Occupational Safety & Health. The National Institute for Occupational Safety and Health (NIOSH), in CDC, conducts a national program of biomedical research in occupational safety and health. NIOSH's corps of multi-disciplinary teams comprising engineers, epidemiologists, industrial hygienists, physicians, and toxicologists perform five basic public health functions to improve the safety and health of workers: (1) determines the nature and extent of the occurrence and causes of work injuries and diseases to target research and prevention activities; (2) detects and investigates workplace health and safety problems, identifying their causes and effects; (3) conducts studies and demonstrations to identify effective engineering solutions, personal protective equipment, work organization and practices, and health communications strategies to prevent work injuries and diseases; (4) develops and disseminates recommendations for assuring the safety and health of workers; and (5) provides leadership and training in occupational safety and health, establishing national research agendas to leverage the impact of government and private sector resources, and training professionals and scientists.

NIH – Research to develop effective treatments for traumatic brain and spinal cord injuries and to understand the long-term consequences of head injury, especially in children, is an important strategy to reduce the impact of injuries. For example, the National Institute of Neurological Disorders and Stroke is supporting projects that include a clinical trial to test the safety of systemic hypothermia to slow down metabolism and thereby inhibit the cascade of biochemical events that immediately follows a head injury and results in brain cell death or damage. Another project will assess the impact of traumatic brain injury (TBI) in children and adolescents on the other family members and the extent to which recovery from pediatric TBI is influenced by the family environment.

Selected FY 2000 Performance Goals and Measures

- ACF, working with its performance partners to assess efforts to remove barriers to work for victims of domestic violence, has proposed the following developmental measure: Increase referrals of clients to self-sufficiency services, child support and child care services. *ACF Plan*

- Increase by 35%, from 120 (1996) to 162, the number of Federally-recognized Indian Tribes that have family violence prevention programs. (Developmental, target level may increase.) *ACF Plan*

- Increase from 7 to 31, the number of community-based intimate partner violence programs in communities with populations at risk for intimate partner violence and associated injuries and deaths. Baseline: 7 community-based programs (1994). *CDC Plan*

- Reduce from 50% (in 1994) to 30%, the number of students reporting incidents of physical fighting among program participants in CDC-funded youth violence projects by the year 2000. Baseline: 50% of students reporting incidents (1994). *CDC Plan*

- Reduce violent victimization inflicted by an intimate assailant to 7 (per 1,000 women) in FY 2000. Baseline: 8 (per 1,000 women in 1992). *OPHS Plan*

- Reduce by 5% (to 117,301) the number of bicycle-related head emergency departments visits by the year 2000. Baseline: 123,475 bicycle-related head injuries (1995). *CDC Plan*

- The incidence of residential fire-related deaths will be reduced from 1.4 per 100,000 in 1994 to 1.1 per 100,000 in 2000. Baseline: 1.4 per 100,000 incidence of residential fire-related deaths (1994). *CDC Plan*

- Develop Sentinel Surveillance System for device injury reporting based on representative user facilities. *FDA Plan*

- Establish an integrated adverse event reporting system for food and cosmetic products with emphasis on increasing efforts to design and implement modules needed to record dietary supplement adverse event information. *FDA Plan*

- By the end of FY 2000, reduce deaths by unintentional injuries for AI/AN people to no more than 90 per 100,000 people. *IHS Plan*

- Reduce the proportion of injurious suicide attempts among youth ages 14-17 to 1.8% in FY 2000. Baseline: 2.8% (1995). *OPHS Plan*

Programs Supporting This Objective

ACF
Family Violence Prevention
CDC
Injury Prevention and Control
Occupational Safety & Health
FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant
Emergency Medical Services for Children
Trauma Care/Emergency Medical Services
Traumatic Brain Injury Program
Poison Control Centers
Trauma Care/Emergency Medical Services
IHS
Prevention
NIH
Research Program
OPHS
Office on Women's Health
Office of the Surgeon General

HHS 1.3: Improve the Diet and the Level of Physical Activity of Americans

From the HHS Strategic Plan, September 1997. Diet-related public health problems are not new in the United States. Forty years ago, diseases arising from deficiencies in nutrients—rickets, malnutrition in children, and night blindness—caused serious concern. Some of these illnesses have been successfully addressed through education and a generally rising economy. Yet, in 1995, despite advances in knowledge about the crucial role of food in health and widespread dissemination of that knowledge in many forms, diet, along with physical activity, figured in four of the ten leading causes of death in the United States: heart disease, certain cancers, stroke, and diabetes mellitus. Together these diseases account for more than 300,000 deaths annually. The costs associated with diet- and activity-related health conditions, including direct health care and lost productivity, is estimated at $56.3 billion a year.

Scientific consensus has emerged around recommendations about diet and physical activity preventing disease and promoting health. The Department's approach is based on this consensus.

Key FY 2000 Activities, Initiatives, and Strategies

- CDC – Chronic Disease Prevention. CDC is taking a crosscutting approach to address the burden of heart disease and other health risks in the U.S. through the prevention of risk factors (e.g., tobacco use, physical inactivity, and poor nutrition), surveillance, epidemiologic research, and health promotion activities. Cardiovascular disease is the leading cause of death in all states; CDC is implementing this approach to heart disease and stroke prevention by building state-specific capacity for cardiovascular health promotion, first in those states with the greatest heart disease and stroke burden. In subsequent years, efforts will expand to create capacity in all states and territories in order to build a nationwide cardiovascular health program.

- CDC – Environmental Disease Prevention. CDC has laid a foundation for a national campaign to encourage folic acid consumption by conducting communication research needed to develop an effective campaign to increase the consumption of supplemental folic acid. The next step is to implement and evaluate state and local programs to conduct educational campaigns and nutritional programs targeted to local women of reproductive age, and to make folic acid awareness a part of the delivery of preventive health care services to women. Hispanic women will be specifically targeted to reduce their disparate increased risk for these serious birth defects.

- IHS – Prevention, Health Education. IHS will assist its partners to engage in community-based prevention initiatives, such as physical inactivity, HIV/AIDS risk behavior, violence prevention, child abuse, alcohol and substance abuse.

- HRSA – Primary Care, Health Centers. Many of HRSA's Health Centers currently provide nutrition and fitness counseling. In FY 2000, HRSA will augment Health Center services to

focus on disparity reduction, particularly for those communities with the highest morbidity and mortality rates for minority populations. The disparity reduction package will include expanding the counseling of patients regarding tobacco, alcohol, and drug use, oral health, fitness, and nutrition.

- AoA – Congregate and Home-Delivered Nutrition Services. AoA supports congregate and home-delivered meal programs to increase the nutritional intake of at-risk seniors. For home-delivered participants, the availability of short term home-delivered meals has been linked with decreased hospital stays in hospitals and intermediate care facilities.

- FDA – Foods, Nutrition Labeling. FDA establishes regulations, policies, and standards for nutrition labeling, dietary supplements and other special nutritional products such as infant formulas and medical foods. Through science-based nutrition policies, FDA provides information to enable consumers to make better dietary choices. To develop the science base for its nutrition policies, the Agency will continue research studies and analysis of scientific and epidemiological data, to better understand the relationships between diet and disease. The food label serves as a primary tool for producers to provide information to consumers about the food's nutritive value and its ingredients as part of a healthy diet. The Agency will also continue to respond to safety concerns associated with the rapidly expanding use and misuse of dietary supplement products such as ephedra.

- NIH – The Five-a-Day for Better Health program is a national public/private partnership nutrition education program which approaches Americans with a simple, positive message–to eat 5 or more servings of fruits and vegetables every day. The National Cancer Institute takes the lead in the program by serving as the credible health source, maintaining scientific integrity, funding research in nutritional behavior change, and organizing and providing technical support to the 55 State and territorial health departments in the Five-a-Day infrastructure.

- NIH – The NIH encourages interdisciplinary interaction between basic and clinical research and stresses the links between nutrition and obesity, diabetes, and other chronic conditions. This effort is supported by NIH through: 1) guidance from the NIH Nutrition Coordinating Committee lead by the National Institute of Diabetes and Digestive and Kidney Diseases, 2) a research portfolio of basic investigations that seek to understand the molecular role of nutrients in health and in the prevention and treatment of disease, and 3) six Clinical Nutrition Research Units and four Obesity/Nutrition Research Centers. The centers provide core resources to a broad base of research investigators.

- AoA – Grants to Indian Tribes. Grants to Indian Tribes and Native Hawaiian Organizations provides funding to Indian tribal organizations, Alaskan Native organizations, and non-profit groups representing Native Hawaiians to provide supportive and nutrition services, including both congregate and home delivered meals to older Native Americans.

- OPHS – To improve health behaviors related to physical activity and diet, OPHS works to engage youth, adults, and the elderly in programs to increase physical activity through coordinated activities related to the Presidential Sports Award (for ages 7 to adult) and the

President's Challenge Physical Fitness Awards Program (for school-based achievement). In addition, the office engages in partnership activities with prominent organizations such as the National Task Force on the Prevention and Treatment on Obesity, International Year of the Older Persons Subcommittee, Partnership for Prevention, Women's Sport's Foundation, Sears, United States Olympic Committee, Metropolitan Life Insurance Company (MetLife), and National Football League (NFL)/Gatorade Punt, Pass & Kick.

At the grassroots level, OPHS enlists the active support and assistance of individual citizens, civic groups, private enterprise, voluntary organizations, and others in efforts to promote and improve physical activity and fitness of all Americans. OPHS encourages the development of community recreation, physical fitness and sports participation programs. It develops and distributes a range of publications to inform the general public of the importance of exercise and the link which exists between regular physical activity and good health.

OPHS works closely with industry, government, and labor organizations to establish sound physical activity, fitness initiatives, and partnerships in an effort to reduce the financial and human cost resulting from physical inactivity. OPHS has also assisted educational organizations at the national, state, and local levels in developing high quality, innovative, comprehensive health and physical education programs which emphasize the importance of exercise and good health.

GirlPower activities work to improve the self esteem of girls and young women so that they adopt healthier lifestyles and reduce their risks for smoking, substance abuse and teen pregnancy.

Selected FY 2000 Performance Goals and Measures

- Reduce diet-related diseases by providing consumers adequate and accurate information on the nutrition content of foods, reduce injuries related to safety hazards in cosmetic products, and prevent food related economic fraud. FY 2000 measure: Increase to at least 55 percent the proportion of adults who report changing their decision to buy or use a food product because they read the food label. Baseline: 48% (1995). *FDA Plan*

- Prevent decline and/or improve nutritional intake of home-delivered participants. FY 2000 measure: Increase in the number of home-delivered meals served to 146 million meals above the 1996 baseline of 119 million meals. *AoA Plan*

- Prevent decline and/or improve nutritional intake of congregate meal program participants. FY 2000 measures: Maintain level of service provision at 118.6 million congregate meals. Maintain number of program participants at 2,147,756. *AoA Plan*

- Improve the health and well-being, and reduce social isolation of older American Indians, Alaska Natives, and Native Hawaiians through the provision of community-based services. FY 2000 measure: Maintain service provision at the level in Fiscal Year 1995. *AoA Plan*

- By 2000, 40% of women of reproductive age will be consuming 0.4 micrograms of folic acid. Baseline: 25% (1996). *CDC Plan*

- By the end of FY 2000, halt the continued increase of obesity in AI/AN 3rd grade children in at least six pilot intervention sites at FY 1999 rate, through the effective implementation of the intervention developed in FY 1999. *IHS Plan*

- Increase the percent of people aged 18-74 who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day to 30% in FY 2000. Baseline: 24% (1991). *OPHS Plan*

Programs Supporting This Objective

AoA
Congregate Meals
Home-Delivered Meals
Grants to Indian Tribes
Supportive Services and Senior Centers
CDC
Chronic Disease Prevention
Environmental Disease Prevention
HRSA
Primary Care, Health Centers

FDA
Foods
IHS
Prevention
NIH
Research Program
OPHS
Office on Women's Health
President's Council on Physical Fitness and Sports
Healthy People, 2010

HHS 1.4: Curb Alcohol Abuse

From the HHS Strategic Plan, September 1997. Alcohol has devastating effects on the health and quality of life of individuals and families in America. More than 100,000 people die from misuse of alcohol each year, with related health and social consequences that cost over $100 billion annually. An estimated 18 million U.S. residents suffer from alcohol dependence, and some 76 million are affected by alcohol abuse at some time during their lives.

Key FY 2000 Activities, Initiatives, and Strategies

- SAMHSA – It has been estimated that only 37% of those who critically need treatment can be served through existing publicly-funded treatment systems. The FY 2000 request proposes increases for two programs which focus specifically on reducing the treatment gap: 1) the Substance-Abuse Prevention and Treatment (SAPT) Block Grant, which will provide for nationwide expansion of treatment services and aid in the reduction of treatment waiting lists; and 2) the Targeted Capacity Expansion program, which will provide rapid and strategic responses to the demand for alcohol and drug abuse treatment services that are more regional or local in nature.

- HRSA – Primary Care, Health Centers. In FY 2000, HRSA will augment Health Center services to focus on disparity reduction, particularly for those communities with the highest morbidity and mortality rates for minority populations. The disparity reduction package will include expanding the counseling of patients regarding tobacco, alcohol, and drug use, oral health, fitness, and nutrition.

- HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports prenatal care programs that encourage healthy maternal behaviors, including risk reduction behaviors, especially for alcohol, tobacco, and substance abuse.

- IHS – Prevention, Alcohol and Substance Abuse, Anti-Drug Abuse Activities, and Mental Health. IHS will assist its partners to engage in community-based prevention initiatives and increase drug-related activities, including treatment, Adolescent Regional Treatment Centers, Community Rehabilitation and Aftercare, Training/Community Education, Health Promotion/Disease Prevention, Navajo Rehabilitation Program Urban Programs, and Contract Health Services.

  Program improvements will continue to focus on the needs of alcohol and substance abusers who have a history of sexual abuse and on a redesigned community mobilization effort that will provide innovative treatment and prevention modules targeting communities that have high rates of alcoholism and drub abuse. Also, IHS efforts will be responsive to changing drug use patterns, such as the increase in methamphetamine use in the Billings Area.

- OPHS – To prevent the abuse of tobacco, alcohol and other drugs by youth, OPHS promotes partnerships with parents and other caregivers, teachers, coaches, clergy, health professionals,

and business and community leaders. Also, OPHS assists in the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use, supports and disseminates scientific research and data on the consequences of legalizing drugs, and promotes other similar activities. Girl Power activities work to improve the self esteem of girls and young women so that they adopt healthier lifestyles and reduce their risks for smoking, substance abuse and teen pregnancy.

SAMHSA – Consistent with the HHS focus on community solutions, the FY 2000 budget request supports the transfer of prevention knowledge from prevention studies to the States and local communities. The State Incentive Grant (SIG) program assists Governors to implement a comprehensive science-based prevention practices directed at reducing youth substance abuse (including alcohol), improving access to needed services and reducing the gap in prevention services.

SAMHSA – Continuing the emphasis on reducing underage drinking, SAMHSA has proposed for FY 2000 a cross-cutting initiative to develop the knowledge needed to guide effective prevention services for two age groups, 9 to 12 and 13 to 17. This proposal also provides funds to expand the Secretary's Youth Substance Abuse prevention Initiative. The Center for Substance Abuse Treatment is collaborating with NIAAA to test the effectiveness of preliminary models for adolescent alcohol abusers and alcoholics.

SAMHSA – The *"Alcohol: We're Not Buying It"* media campaign targets alcohol use among underage youth.

NIH – The prevalence of alcohol abuse among adolescents has increased NIH's emphasis on the development of new prevention and treatment strategies against alcoholism and alcohol abuse. For example, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has identified a variety of initiatives associated with its focus on alcohol treatment for adolescents. These initiatives include soliciting studies that will provide a scientifically-informed basis for developing effective adolescent treatment strategies, including consideration of different cultural and gender needs. Such studies might, for example, contrast integrated treatment regimes designed to address the gamut of adolescent lifestyle issues with programs more specifically focused on alcohol abuse itself.

Selected FY 2000 Performance Goals and Measures

♦ By the end of FY 2000, increase follow-up for youth discharged from adolescent Regional Treatment Centers such that 60% receive at least three follow-up contacts per year. *IHS Plan*

♦ Reduce the death rate for alcohol-related motor vehicle crashes to 5.5 (per 100,000) in FY 2000. Baseline: 6.5 (per 100,000 in 1995). *OPHS Plan*

♦ Reduce heavy drinking in past two weeks by high school seniors to 28% in FY 2000. Baseline: 30% (1995). *OPHS Plan*

♦ The following are developmental measures for the SAPT Block Grant; performance baselines and targets for FY 1999 and 2000 are not currently available. SAMHSA and State agencies are negotiating performance measures at the present time. *SAMHSA Plan*

Increase in the percent of adults receiving services who:
- were currently employed or engaged in productive activities;
- had no/reduced involvement with the criminal justice system;
- experienced no/reduced alcohol or illegal drug related health, behavior, or social consequences;
- had no past month substance abuse.

Increase in the percent of children under 18 receiving services who:
- were attending school;
- were residing in a stable living environment;
- had no/reduced involvement in the juvenile justice system;
- had no past month use of alcohol or illegal drugs;
- experienced no/reduced substance abuse related health, behavior, or social consequences.

Programs Supporting This Objective

HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant
IHS
Treatment
Prevention
NIH
Research Program
OPHS
Healthy People 2000
Girl Power
Office on Women's Health
SAMHSA
Knowledge Development and Application
Targeted Capacity Expansion
High Risk Youth
National Data Collection State Infrastructure
Substance Abuse Prevention and Treatment Block Grant

HHS 1.5: Reduce the Illicit Use of Drugs

From the HHS Strategic Plan, September 1997. Approximately 20,000 preventable deaths a year are attributable to the use of illicit drugs and the illicit use of prescription drugs. Such illicit uses contribute to suicide, homicide, motor vehicle injury, HIV infection, pneumonia, hepatitis, tuberculosis, sexually transmitted diseases, and endocarditis. While an estimated 3 million people in the United States have serious drug problems, fewer than a million are in treatment at any given time. Apart from the loss of life, the additional social costs—worsening crime rates, and community and family disintegration—are severe. These in turn compromise other important influences on health such as income, education, and family stability.

Key FY 2000 Activities, Initiatives, and Strategies

- SAMHSA – The Targeted Capacity Expansion program supports a two-prong strategy to reduce/eliminate substance abuse and its related problems. First, the State Incentive Grant (SIG) Program extends ability of the Center for Substance Abuse Prevention (CSAP) to help States improve their prevention service capacity. Funding enables States to examine their state prevention systems, and create Statewide networks of public and private organizations to extend the reach of the primary prevention portion of the SAPT Block Grant and optimizing the application of State and Federal substance abuse funding streams. Eighty-five percent of SIG funds are directed toward implementing best practices within local programming to target prevention service needs within their states and reduce the gap in prevention services. In this way, SIG funds not only help improve access to needed services, they also improve the quality of the prevention services provided. Second, the five Centers for the Application of Prevention Technologies (CAPTS) and the U.S.-Mexico Border CAPT support the SIGs, other States and their communities by transferring research-based knowledge and delivering tailored technical assistance, training, and supportive materials to meet the unique needs of communities and States in their respective geographical areas.

- HRSA – Primary Care, Health Centers. In FY 2000, HRSA will augment Health Center services to focus on disparity reduction, particularly for those communities with the highest morbidity and mortality rates for minority populations. The disparity reduction package will include expanding the counseling of patients regarding tobacco, alcohol, and drug use, oral health, fitness, and nutrition.

- HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports prenatal care programs that encourage healthy maternal behaviors, including risk reduction behaviors, especially for alcohol, tobacco, and substance abuse.

- SAMHSA – Consistent with the HHS focus on community solutions, funding will be provided to the States/Governors to examine their State Prevention Systems and redirect State resources to critical targeted prevention service needs within their states. Eighty-five percent of SIG funds will be directed toward implementing science-based practices, improving access to needed services and reducing the gap in prevention services.

- SAMHSA – The National Clearinghouse for Alcohol and Drug Information continues to respond to the inquiries generated by the ONDCP National Anti-Drug Media Campaign and the thousands of public requests for information about causes, consequences, and effective strategies used to address substance abuse and its related problems.

- SAMHSA – The five Centers for the Application of Prevention Technologies (CAPTS) and the U.S.-Mexico Border CAPT support the SIGs, other States and their communities by transferring research-based knowledge and delivering tailored technical assistance, training, and supportive materials to meet the unique needs of communities and States in their respective geographical areas.

- SAMHSA – The National Center for the Advancement of Prevention II develops knowledge-based tools, principles and models useful for developing prevention plans and programs available to States, communities, and local prevention practitioners and policy makers to improve the effectiveness of prevention efforts across the nation.

- SAMHSA **–** The Prevention Enhancement Protocol System (PEPS) is a pioneering initiative that develops program and intervention guidelines for the field using established "rules of evidence" for assessing practice and research findings and combining this evidence into prevention approaches.

- CDC – HIV/AIDS Prevention. CDC provides HIV prevention funding to state and local health departments and education agencies, community-based organizations, minority-based organizations, national organizations, universities, and hospitals targeted to populations at high risk for HIV, including injecting drug users. A portion of health department funding supports HIV counseling and testing, including partnership notification in drug treatment settings. In FY 2000, additional funds are being requested which will be used to evaluate and expand CDC's partner counseling and referral services for persons whose sex and drug using behaviors place them at high risk for HIV and other STDs.

- IHS – Prevention, Alcohol and Substance Abuse, Anti-Drug Abuse Activities, and Mental Health. IHS will assist its partners to engage in community-based prevention initiatives and increase drug-related activities, including treatment, Adolescent Regional Treatment Centers, Community Rehabilitation and Aftercare, Training/Community Education, Health Promotion/Disease Prevention, Navajo Rehabilitation Program Urban Programs, and Contract Health Services.

  Program improvements will continue to focus on the needs of alcohol and substance abusers who have a history of sexual abuse and on a redesigned community mobilization effort that will provide innovative treatment and prevention modules targeting communities that have high rates of alcoholism and drub abuse. In addition, IHS efforts will be responsive to changing drug use patterns, such as the increase in methamphetamine use in the Billings Area.

- HCFA – Various forms of drug abuse treatment are provided for both Medicaid and Medicare beneficiaries. Under Medicaid, States must pay for the inpatient, outpatient, and physician

services for eligible persons, and (at the States' option), clinic and rehabilitative services. Medicare-eligible individuals requiring drug abuse treatment can receive all covered hospital and some non-hospital services necessary to treat their condition. Medicare primarily covers inpatient hospital treatment of episodes of alcohol or drug abuse, as well as some medically reasonable and necessary services in outpatient settings for the continued care of these patients.

OPHS – To prevent the abuse of tobacco, alcohol and other drugs by youth, OPHS promotes partnerships with parents and other caregivers, teachers, coaches, clergy, health professionals, and business and community leaders. Also, OPHS assists in the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use, supports and disseminates scientific research and data on the consequences of legalizing drugs, and promotes other similar activities. GirlPower activities work to improve the self esteem of girls and young women so that they adopt healthier lifestyles and reduce their risks for smoking, substance abuse and teen pregnancy.

NIH – Support of a *National Drug Treatment Clinical Trial Network* is critical as a strategy to ensure that the most effective drug addiction treatment approaches are used in combating drug abuse and addiction. In this area, the *Treatment Initiative* of the National Institute on Drug Abuse (NIDA) focuses on improving drug abuse and addiction treatment through both basic and clinical research with particular emphasis on medications development, behavioral treatments, and testing these approaches in real life settings. As a result of advances in neuroscience and behavioral science research, there are a number of pharmacological and behavioral treatments for drug addiction that are ready to move into phase III clinical testing. NIDA will begin to develop a clinical trials infrastructure, similar to that of other NIH institutes, to more rapidly and efficiently test in real-life settings the efficacy of behavioral, psychosocial and pharmacological treatments through large-scale, multi-site clinical trials.

Selected FY 2000 Performance Goals and Measures

♦ The number of AIDS cases related to injecting drug use will be decreased by 10% from the 1995 base of 15,700 cases diagnosed. *CDC Plan*

♦ By the end of FY 2000, increase follow-up for youth discharged from adolescent Regional Treatment Centers such that 60% receive at least three follow-up contacts per year. *IHS Plan*

♦ Reduce the use of marijuana in the past month among 12- to 17-year-olds to 3.2% in FY 2000. Baseline: 8.2% (1995). *OPHS Plan*

♦ The following are developmental measures for the SAPT Block Grant; performance baselines and targets for FY 1999 and 2000 are not currently available. SAMHSA and State agencies are negotiating performance measures at the present time.

Increase in the percent of adults receiving services who:

- were currently employed or engaged in productive activities;
- had no/reduced involvement with the criminal justice system;

- experienced no/reduced alcohol or illegal drug related health, behavior, or social consequences;
- had no past month substance abuse.

Increase in the percent of children under 18 receiving services who:
- were attending school;
- were residing in a stable living environment;
- had no/reduced involvement in the juvenile justice system;
- had no past month use of alcohol or illegal drugs;
- experienced no/reduced substance abuse related health, behavior, or social consequences. *SAMHSA Plan*

Programs Supporting This Objective

CDC
HIV/AIDS Prevention
HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant
IHS
Treatment
Prevention
NIH
Research Program

OPHS
Healthy People 2000
Office of Disease Prevention and Health Promotion
Girl Power
Office on Women's Health
SAMHSA
Knowledge Development and Application
Targeted Capacity Expansion
High Risk Youth
National Data Collection State Infrastructure
Substance Abuse Block Grant

HHS 1.6: Reduce Unsafe Sexual Behaviors

From the HHS Strategic Plan, September 1997. Unsafe sexual behavior contributes to the most rapidly spreading diseases in the country, such as chlamydia, gonorrhea, syphilis, HIV infection, genital herpes, human papilloma virus, and hepatitis B, and to their complications in infant mortality, cervical and liver cancers, pelvic inflammatory disease, and AIDS. In addition, unsafe sexual behavior among teens can result in unintended pregnancies, a potentially life-damaging consequence of adolescent sexual experimentation.

Key FY 2000 Activities, Initiatives, and Strategies

CDC – HIV/AIDS Prevention. CDC funds local prevention activities, provides technical assistance, research social/behavioral interventions, and facilitates linkages with health care activities for persons at risk for HIV/AIDS. CDC works in collaboration with many other governmental and non-governmental organizations and agencies at national, regional, state and local levels to implement, evaluate, and further develop and strengthen effective HIV prevention programs across the United States. CDC also provides financial and technical support for disease surveillance.

  Risk behaviors for school-aged youth are readily understood because of CDC's Youth Risk Behavior Surveillance System (YRBSS). The YRBSS is designed to focus attention on priority behaviors that cause the most important health problems, and it was developed in partnership with numerous federal agencies, state departments of education, scientific experts, and survey research specialists.

  Research has demonstrated that HIV education in schools can be effective in reducing risk behaviors among youth. CDC's efforts to help state and local education agencies implement HIV prevention education programs in schools nationwide include teacher training programs, dissemination of model policies and effective prevention programs, and evaluation technical assistance.

CDC – Sexually Transmitted Diseases (STD). CDC provides national and international leadership through research, policy development, and support of effective services to prevent and control the transmission of STDs and their complications. Specific areas where assistance is provided are: monitoring disease trends; behavioral, clinical, and health services research; education and training; building partnerships for STD prevention; implementing the Comprehensive STD Prevention System; and conducting the Infertility Prevention Demonstration.

Administration Initiative – Family Planning. The HHS budget promotes family planning services to help American women prevent over 1 million unintended pregnancies each year. The President's Budget proposes an additional $25 million over the FY 1999 appropriation to serve 4,600 family planning clinics. This funding expands efforts to reduce unintended pregnancies and sexually transmitted diseases for groups with high unintended pregnancy

rates. These efforts will promote responsibility for healthy reproductive lifestyles emphasizing hard to reach populations.

OPHS/HRSA – Family Planning Program. The Title X family planning program will continue providing a comprehensive range of family planning services to all persons desiring such services, including adolescents. Title X will also enhance partnerships with other community-based health and social service organizations.

  In addition to service provision, the Title X program also supports three key functions aimed at assisting clinics in better responding to clients needs: training for family planning clinic personnel, as well as through five accredited nurse practitioner training programs; information dissemination and community-based education and outreach activities; and research to improve the delivery of family planning services.

OPHS – The Adolescent Family Life (AFL) program supports demonstration projects to develop models aimed at (1) promoting abstinence from sexual intercourse as a means of preventing adolescent pregnancy and sexually transmitted diseases, including HIV, and (2) assisting pregnant and parenting adolescents, their children and their families. The program also funds research projects examining the causes and consequences of adolescent premarital relations, adolescent pregnancy and adolescent parenting.

SAMHSA – Project SHIELD focuses on changing unsafe sexual behaviors of women and adolescents. Funded by the Center for Mental Health Services, this program examines the relative effectiveness of three approaches to reducing high risk sexual behavior which is involved in the sexual transmission of the HIV virus.

SAMHSA – The Targeted Capacity Expansion program establishes a Substance Abuse and HIV (SA/HIV) Prevention Consortium that will provide policy advice/consultation on issues related to improving SA/HIV prevention services to specific populations. Supplements will be provided to CSAP's six Centers for the Application of Prevention Technologies for the integration of HIV prevention materials, expansion of training and TA.

HRSA – HIV/AIDS, HIV Pediatric Grants. HRSA will improve the infrastructure of comprehensive care services in order to increase the access of HIV/AIDS-affected women, infants, children and youth to a comprehensive, community-based, family-centered system of care.

HRSA – Primary Care, Health Centers. All of HRSA's Health Centers provide family planning and STD screening; many have special programs in schools and in the community to reduce teen pregnancy and unsafe sexual behavior.

HRSA – Maternal and Child Health Block Grant, Abstinence Education Program. This program provides formula grants to the States for the purpose of providing abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock.

HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports the Girl Neighborhood Power program to promote the health and well being of female adolescents between the ages of nine and fourteen, and to prevent the onset of health risk behaviors during their adolescence.

IHS – Prevention, Health Education. IHS will assist its partners to engage in community-based prevention initiatives, such as HIV/AIDS risk behavior, violence prevention, child abuse, physical inactivity, alcohol and substance abuse.

NIH – More than 13 million Americans each year acquire infectious diseases other than AIDS through sexual contact. Such Sexually Transmitted Diseases (STD) as gonorrhea, syphilis, chlamydia, genital herpes, and human papillomavirus can have devastating consequences, particularly for young adults, pregnant women, and newborn babies. NIAID-supported scientists in STD Cooperative Research Centers, NIAID laboratories, and other research institutions are developing better diagnostic tests, improved treatments, and effective vaccines. In addition to NIAID, research on sexually transmitted diseases is funded by other Institutes at the NIH.

NIH – Drug abuse is currently the fastest growing vector for the spread of HIV in the United States, and all drug users place themselves at great risk for infectious disease transmission when engaging in unsafe sexual behavior while under the influence of drugs. Since the discovery of the connection between the injection of drugs and the transmission of HIV, the National Institute on Drug Abuse has been conducting research to better understand this association, and to disseminate its research findings to ensure that effective prevention and treatment programs are developed. Research will continue to concentrate on the development of more effective treatment, prevention, and outreach programs to change behaviors, which in turn saves lives and enormous costs to society.

OPHS – GirlPower activities work to improve the self esteem of girls and young women so that they adopt healthier lifestyles and reduce their risks for smoking, substance abuse and teen pregnancy.

Selected FY 2000 Performance Goals and Measures

♦ The number of heterosexually-acquired AIDS cases will be decreased by 10% from the 1997 base of 11,500 AIDS cases diagnosed. *CDC Plan*

♦ The number of AIDS cases related to injecting drug use will be decreased by 10% from the 1995 base of 15,700 cases diagnosed. *CDC Plan*

♦ The number of AIDS cases related to male homosexual contact will be decreased by 10% from the 1997 base of 21,300 cases diagnosed. *CDC Plan*

- Increase the number of enrolled female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal HIV transmission. *HRSA Plan*

- Increase the percentage of persons who return for their HIV test results and posttest counseling from 61% in 1996 to 67% in 2000 (10% relative increase). *CDC Plan*

- The prevalence of *Chlamydia trachomatis* among high risk women under 25 will be reduced from 11.6% (1995) to less than 8%. *CDC Plan*

- Reduce the proportion of young persons (15-24 years old) with Chlamydia trachomatis infections to 5.0% in FY 2000. Baseline: 4.7% (females in family planning clinic), 12.3% (females in STD clinic), 15.7% (males in STD clinic) (1997). *OPHS Plan*

- The incidence for gonorrhea in women aged 15-44 will be reduced from 300 per 100,000 (1995) to less than 200 per 100,000. *CDC Plan*

- At least 85% of U.S. counties will have an incidence of primary and secondary syphilis in the general population of less than or equal to 4 per 100,000. This is an increase from 81% in 1995. *CDC Plan*

- Achieve State-set rates for reducing the incidence of youths 15-19 years old who have contracted selected sexually transmitted diseases in 50 percent of the participating States. FY 2000 measure: Percentage of participating states that achieve state-set targets. Baseline: Target date of September, 1999 for data. [Developmental] *HRSA Plan*

- The percentage of high school students who have ever engaged in sexual intercourse will be reduced by 10%, and the percentage of currently sexually active high school students who engage in sexual intercourse without a condom will be reduced by 10%. Baseline: 53% of students ever engaged in sexual intercourse and 46% of students engage in sexual intercourse without a condom (1995). *CDC Plan*

- Achieve State-set targets for reducing the proportion of adolescents who have engaged in sexual intercourse in 50 percent of the participating States. FY 2000 measure: Percentage of participating states that achieve state-set targets. Baseline: Target date of September, 1999 for data. [Developmental] *HRSA Plan*

- Achieve State-set targets for reducing the rate of births to teenagers aged 15-17 in 50 percent of the participating States. FY 2000 measure: Percentage of participating states that achieve state-set targets. Baseline: Target date of September, 1999 for data. [Developmental] *HRSA Plan*

- Increase the proportion of all females ages 15-44 at risk of unintended pregnancy who ever use contraception to 95% in FY 2000. Baseline: 92.5% (1995). *OPHS Plan*

Programs Supporting This Objective

CDC
HIV/AIDS Prevention
Sexually Transmitted Diseases
HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant
Abstinence Education Program
Maternal and Child Health Block Grant
HIV/AIDS, HIV Pediatric Grants
IHS
Prevention

NIH
Research Program
OPHS
Office of Disease Prevention and Health Promotion
Office on Women's Health
Office of Population Affairs
Healthy People 2000
OPHS/HRSA
Family Planning
SAMHSA
Knowledge Development and Application

HHS Goal 2: IMPROVE THE ECONOMIC AND SOCIAL WELL-BEING OF INDIVIDUALS, FAMILIES AND COMMUNITIES IN THE UNITED STATES

From the HHS Strategic Plan, September 1997. Achieving a society in which each person, regardless of age, sex, physical ability, or racial/ethnic background, has the opportunity to lead an economically and socially productive life is central to the Department's vision for the future. Realizing this vision requires that we support strategies that create opportunities for individuals, families, and communities—a responsibility that the Department of Health and Human Services (HHS) shares with other federal agencies, state, local, and tribal governments, and the private sector.

Families, Children and Communities. The Department has identified five important areas in which it has developed strategies to foster the healthy development of children and to strengthen the ability of families to care for them. These areas are economic security, family stability, personal responsibility, healthy development of children, and strong communities.

In addressing these five areas, our guiding principle is to maximize opportunities and reduce barriers to independence and self-sufficiency for those on welfare and for the working poor. Children and adults without adequate income are denied the full benefits of living in our society. Sustained unemployment is discouraging and counterproductive to responsible parenting and citizenship. Our emphasis is on moving families from welfare to work, short-term financial aid coupled with education, training, job services and child care; and gainful employment and quality child care for low-income working families.

In addition, sound growth and development are basic needs if children are to become productive adults and citizens. Recent research has documented the importance of early brain development and preschool experiences on later development. Our Early Head Start, Head Start, and quality child care programs for low-income children are essential to health, early development and school readiness; and child care before and after school and youth development services are necessary to sustain positive effects. Our efforts to promote economic independence and to strengthen families and communities also have a bearing on children's development.

Finally, communities provide the context within which families may function well or poorly. Communities are constantly adapting to social and economic challenges. Dramatic changes in progress require special attention for those who are economically disadvantaged and for distressed communities. The Department, along with the Department of Housing and Urban Development (HUD) and others, is committed to economic development and linking comprehensive community development "place" strategies with comprehensive "people" strategies to help communities to function as a positive factor in the lives of community residents.

People with Disabilities. The Department has also identified significant barriers to independence faced by working-age adults with disabilities (those aged 18–64). People with disabilities typically report that they want to work, but need personal assistance services or devices in order to do so.

Others will not risk working because they cannot afford to lose the health and long-term care coverage they have under Medicaid or Medicare. Thus, while a large majority of working-age people with disabilities (90.7 percent of men and 74.4 percent of women) are in the labor force, that is, they are either employed or looking for work, individuals with functional disabilities are far less likely to be in the labor force (67.3 percent and 52.3 percent, respectively). The Department will work to provide access to health coverage and a wide range of supports for daily living activities needed by people with disabilities to facilitate their participation in the work force and full participation in community life. For those unable to work, the Department will provide similar supports necessary for independent living and integration in the community.

The Aging Population. The paradigm of aging as a state of dependency does not fit today's elderly who want to lead active and independent lives. A new paradigm is needed that recognizes the desire and ability of many seniors to remain engaged in economically and socially productive activities. The Department will support this "active aging" by working to eliminate barriers presented by the current health and social service systems. Doing so calls for adequate community-based and long-term care services for a growing number of elderly who need significant help if they are to continue living independently.

The objectives and strategies that follow set forth the Department's approach to supporting economic self-sufficiency for families with children; fostering safe, stable, and prosperous communities; promoting sound developmental foundations for children; and providing needed assistance for the elderly and persons with disabilities. The Department's efforts will be carried out through partnerships with the private sector and with the state, local, and tribal governments that implement most of its programs.

HHS 2.1: Increase the Economic Independence of Families on Welfare

From the HHS Strategic Plan, September 1997. On August 22, 1996, the President signed into law the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which created Temporary Assistance for Needy Families (TANF) and significantly improved and expanded the Child Support and Child Care programs. These programs are important to the strategies discussed here and in other strategic objectives. TANF gives states and tribal governments unprecedented flexibility to design programs that promote work, responsibility, and self-sufficiency. It has transformed welfare from an entitlement to individuals into a variety of programs in states and counties that require work and provide time-limited assistance. The nation has an enormous stake in this new approach to public assistance. The Administration for Children and Families (ACF) leads the Department-wide effort to help state and tribal governments as they design and implement their programs and move clients from welfare to work, while protecting the well-being of children through child care and other services.

Key FY 2000 Programs, Initiatives, and Strategies

- ACF – Temporary Assistance for Needy Families. TANF promotes work, responsibility and self-sufficiency and strengthens families through funding of State-designed and -administered programs that provide support to needy children and move their parents into work.

- Administration Initiative – Making Child Care Safe, Reliable, and Affordable. This comprehensive initiative comprises approximately $20 billion over five years for HHS, and the Departments of Treasury and Education. The initiative helps working families access and pay for child care, along with helping States and communities improve the safety and quality of care.

  HHS proposes a $7.5 billion expansion over five years of the Child Care and Development Block Grant Act (CCDBG). These entitlement funds help working parents pay for care and—when combined with child care funds from welfare reform—enable States to provide child care assistance to over 2.4 million children by 2004. This represents an increase of over 1 million children above the 1997 level. Funds will be allocated to States by a matching formula and distributed to families to help them pay for child care.

  This budget also proposes an Early Learning Fund to enhance early childhood development, and improve emergent literacy and school readiness. This initiative, totaling $3 billion over five years, provides matched challenge grants for States to distribute to communities for improving early learning and the quality and safety of child care.

- ACF – Child Care. ACF is again requesting funding for the President's five year initiative to address and expand activities related to three key issues: affordability, quality and availability. These funds will help provide support for working families in their effort to access quality care for their children. These new funds, combined with the child care funds provided in welfare

reform, will enable the program to serve 2.4 million children by 2004, an increase of over one million since 1997.

- HRSA – Healthy Start. HRSA will fund approximately 13 additional new Healthy Start projects targeting communities with high infant mortality and other socioeconomic risk factors. With these additional projects, HRSA will be funding approximately 95 communities (20 mentoring projects and 75 replication projects) to reduce barriers to care, improve perinatal systems, support private sector partnerships that facilitate welfare to work and community job creation, and reduce racial disparity in health status.

- HRSA – Primary Care, Health Centers. Many of HRSA's Health Centers hire and train former welfare recipients from the community as outreach and health promotion workers.

- ACF – Refugee Resettlement. ACF helps refugees and Cuban and Haitian entrants who are admitted to the United States to become employed and self-sufficient as quickly as possible through providing cash and medical assistance to refugee households that are not eligible for TANF, Medicaid and SSI during their first months in the United States; and English language training, employment-related services.

- SAMHSA – The Parenting Adolescents program is building the knowledge base about the effects of welfare reform on parenting teens and measuring the effects of preventive interventions tailored to this population. The program is helping parenting teens resist substance abuse, improve academic achievement and complete school, avoid repeat pregnancies, and improve their parenting skills and their overall health and well-being.

- ASPE – Policy Research. ASPE will continue to develop new data infrastructures to monitor the impact of rapidly evolving welfare systems being implemented at the state and community level. It is also critical to understand the interaction of these systems with the provision of health services.

- OCR – Preventing Discrimination in Access to HHS' Services. OCR will work in partnership with ACF and others to ensure that TANF programs are implemented in a nondiscriminatory manner. One area in which OCR Regional Offices have noted potential compliance problems that may impede some TANF recipients from making the successful transition to work is in the availability of day care for children with a variety of disabilities. In cases involving dismissal or non-acceptance in programs, OCR has reviewed and taken corrective actions to ensure that appropriate individualized assessments and physical and other accommodations are considered in determining acceptance and/or retention in a day care program.

Selected FY 2000 Performance Goals and Measures

- All States meet the TANF work participation targets (the targets are statutory) for FY 2000: all families, 40%; two parent families, 90%. *ACF Plan*

- Increase from the FY 1998 baseline year the number of adult TANF recipients and former recipients employed in one quarter of the year who continue to be employed in the subsequent quarter. [Developmental] *ACF Plan*

- Increase the number of State and local welfare agencies and service providers administering TANF that are in compliance with Title VI, Section 504 and the ADA. FY 2000 measure: 18 corrective actions and no violation findings. Baseline: 8 corrective actions and no violation findings FY 98. *OCR Plan*

- Increase the number of refugees entering employment in FY 2000 through ACF-funded refugee employment services by at least 5% annually from the FY 1997 actual performance of 46,800 to 54,177. *ACF Plan*

- To assess its goal to increase the number of children of low income working families and families in training and education who have access to affordable child care, ACF is working with its partners to refine the following proxy measure in FY 1999: Increase the number of children receiving subsidized child care from the 1997 baseline average of 1.25 million served per month. *ACF Plan*

Programs Supporting This Objective

ACF
Temporary Assistance for Needy Families
Refugee Resettlement
Social Services Block Grant
Child Care
ASPE
Policy Research

HRSA
Healthy Start
Primary Care, Health Centers
OCR
Preventing Discrimination in Access to HHS' Services
SAMHSA
Parenting Adolescents

HHS 2.2: Increase the Financial and Emotional Resources Available to Children From Their Noncustodial Parents

From the HHS Strategic Plan, September 1997. Parents have a responsibility to support their children, financially, emotionally, and socially. In the case of single-parent families, financial support from noncustodial parents is essential to the economic security of the child and of its custodial parent. If every parent paid the child support he or she legally owes, fewer families would need welfare. The Urban Institute estimates an additional $34 billion in child support could be collected if all children living with a single mother had child support orders and all child support orders were based on uniform national guidelines. Emotional and social support is equally essential to the child's sound growth and development. To address these issues, the Department is committed to working with states to enforce payment of legally owed child support aggressively, to establish paternities, and to promote the involvement of noncustodial fathers in their children's lives.

Key FY 2000 Activities, Initiatives, and Strategies

ACF – Child Support Enforcement. ACF will continue to provide direction, guidance technical assistance, oversight, and some services to States' CSE Programs to aggressively enforce payment of legally owed child support, to establish paternities, and to promote the involvement of noncustodial fathers in their children's lives.

Early interventions will be sought through expanding in-hospital based paternity establishment programs and partnering with birth record agencies, pre-natal clinics and other entities, encouraging voluntary acknowledgments, in accordance with the requirements of PRWORA. Focus will be placed on improved enforcement techniques with emphasis on automated mechanisms for enforcement, collections and payments to families.

ACF will continue efforts to involve fathers in the lives of their children through several means: first focusing attention on the positive role fathers have in improving their children's well-being; second, ensuring that the HHS research agendas pay adequate attention to the role of fathers in families and the effects of fathering on children's well-being; third, using positive messages and language regarding fathers and fatherhood in publications and announcements; and, finally, ensuring that HHS's own workforce policies encourage and enable fathers to balance work and family life responsibilities.

Selected FY 2000 Performance Goals and Measures

- Increase the paternity establishment percentage among children born out-of-wedlock to 96% (1996 baseline 75%). *ACF Plan*

- Increase the percentage of IV-D cases having support orders to 76% (1996 baseline 59.4%). *ACF Plan*
- Increase the IV-D collection rate for current support to 71% (1996 baseline 53%). *ACF Plan*

- Increase the percentage of paying cases among IV-D arrearage cases to 46% (1996 baseline 35%). *ACF Plan*

Programs Supporting This Objective

ACF
Child Support Enforcement

HHS 2.3: Improve the Healthy Development and Learning Readiness of Preschool Children

From the HHS Strategic Plan, September 1997. Children who reach school ready to learn—physically healthy and socially and emotionally well-developed—are likely to succeed in school and to go on to secure and productive lives. Extensive research confirms the positive outcomes for children in high-quality early childhood programs. Moreover, recent research on brain development sponsored by the National Institutes of Health (NIH) has given us new insights into the importance of children's day-to-day social interactions for healthy development, and has shown us the extent to which emotional, social, and cognitive development are interconnected. Interventions in infancy and early childhood with those who are vulnerable have been shown to be cost effective and are essential to preventing more costly mental, developmental, and social problems.

Key FY 2000 Activities, Initiatives, and Strategies

ACF – Head Start. ACF plans to increase participation by nearly 42,000 preschool children, infants, toddlers, and their families, moving toward the President's goal of serving 1 million children in Head Start and doubling the size of Early Head Start by 2002.

Early Head Start. ACF will increase the number of infants and toddlers and their families in the Early Head Start program, as well as expanding technical assistance, training, and research to support top quality infant and toddler programs nationwide.

Partnerships. In keeping with the Department's own vision of strong foundations for children's development that cut across programmatic lines, ACF will continue to expand the ability of Head Start programs to work with others in communities and states across the country on an integrated vision of top quality early childhood services. ACF is identifying and disseminating community models of Head Start-child care collaborations; developing new and stronger links with the Department of Education and local school districts; and strengthening the State Collaboration offices, which support linkages between Head Start and state early childhood and related offices in all 50 states.

Administration Initiative – Enhancing Head Start. The FY 2000 budget request seeks $5.3 billion, an increase of $607 million over FY 1999, for Head Start to serve an additional 42,000 children. This level of funding provides Head Start to a total of 877,000 children and their families. The Administration thus reinforces its commitment to enrolling one million children by 2002. Plans include improving program quality, obtaining safer equipment, improving classroom facilities, and reducing staff turnover.

Administration Initiative – Making Child Care Safe, Reliable, and Affordable. This comprehensive initiative comprises approximately $20 billion over five years for HHS, and the Departments of Treasury and Education. Included in this initiative is a proposal for an Early Learning Fund to enhance early childhood development, and improve emergent literacy and

school readiness. This initiative, totaling $3 billion over five years, provides matched challenge grants for States to distribute to communities for improving early learning and the quality and safety of child care.

- IHS – Treatment and Prevention. Through an Interagency Agreement with Head Start, IHS health care consultants and providers prioritize Head Start children for essential services and provide training and technical assistance to Head Start staff at the local level.

- ACF – Child Care. ACF will work with State administrators, professional groups, service providers, and others to identify elements of quality in child care and appropriate measures; to inform States, professional organizations, and parents about what constitutes quality in child care; to influence the training of child care workers and accreditation; to improve linkages with health care services, Head Start, and Early Head Start.

- HRSA – Primary Care, Health Centers. HRSA will develop additional primary care access points and serve approximately 9.025 million persons in FY 2000, an increase of 125,000 over FY 1999. HRSA will target new and currently served communities for investment based on health status gaps, unmet need, potential for increasing access and reducing disparities, as well as children reached through the Outreach Program. In addition, the Health Centers have mounted a major initiative to increase childhood immunization rates in collaboration with CDC. This initiative has already shown significant progress in nine states.

- Administration Initiative – Promoting Childhood Immunizations. The HHS budget proposes $1.1 billion for childhood immunizations, including the Vaccines for Children program and CDC's discretionary immunization program. The Nation surpassed its childhood vaccination goals for 1997—90 percent or more of America's toddlers received each basic childhood vaccine—as a result of the Administration's initiative. The incidence of vaccine-preventable diseases such as diphtheria, tetanus, measles and polio are at all-time lows. Expanded funding will permit continued high levels of childhood immunization. The FY 2000 budget also includes $83 million to eradicate polio, an increase of $17 million.

- FDA – Drugs, Vaccines. FDA has the responsibility for ensuring that vaccines and related products are safe, effective, and adequately labeled. Vaccines against ten diseases (Hepatitis B, polio, Haemophilus influenzae type b, mumps, measles, rubella, diphtheria, tetanus, pertussis, and chicken pox) are recommended for all U.S. children.

  For the past decade, the development of an acellular pertussis vaccine for infant immunization has been a major national goal. FDA has played a major role in developing and standardizing these vaccines. Currently, three acellular pertussis vaccines are licensed for infants (one in 1996 and two in 1997), and several additional acellular vaccines are now under review. FDA anticipates that these vaccines, especially when combined with other routine pediatric vaccines, will replace whole cell pertussis vaccines in the United States. Combination vaccines reduce the number of needle sticks to children and the number of visits to health care providers, and are a current FDA priority. The Agency released a guidance document on combination vaccines this year.

- HCFA – Childhood immunization is a key element of the healthy development of preschool children, and is recognized as such by the Children's Health Insurance Program (CHIP). Under CHIP legislation, States that create a separate CHIP program must include coverage of the complete series of immunizations. States also are prohibited from imposing co-payments or deductibles on immunization services. Almost all of the CHIP State Plans submitted to HCFA by April 1998 indicated the intention to apply a measure of childhood immunization to their CHIP population as a basic indicator of quality of care.

  Moreover, highly effective, evidence-based interventions are available to raise childhood immunization coverage levels. A large number of studies have shown that performance measurement through HEDIS®, registries, or other assessment techniques and the use of recall and reminder systems to identify and track children in need of vaccination will substantially raise coverage levels. A major barrier to childhood immunization is the information gap that exists among parents and providers about the immunization status. Research indicates that over three-fourths of parents of children in need of immunization believe their child is completely vaccinated. Similarly, providers also tend to greatly over-estimate the immunization coverage levels of their patients. This information gap is an important reason why both performance measurement and recall and reminder systems are highly effective, evidence-based intervention strategies that are recommended by both the Centers for Disease Control and the Advisory Committee on Immunization Practices.

- CDC – Immunizations. The National Immunization Program (NIP) focuses on several major programmatic areas to achieve its goals, including childhood immunization, adult immunization, and global polio eradication. Although NIP has assistance from many partners, State and local health agencies play a primary role in helping NIP carry out its mission in the United States. State and local health agencies use CDC grant funds for a wide range of activities including hiring staff, conducting surveillance, assessing immunization levels, developing immunization registries, conducting education and outreach, and establishing partnerships with community groups and private sector organizations.

- SAMHSA – The Starting Early Starting Smart program, a collaborative effort of SAMHSA's three Centers and the Casey Family Program, is generating new empirical knowledge about the effectiveness of integrating substance abuse prevention, substance abuse treatment and mental health services for children ages zero to seven who experience multiple risk factors for substance abuse or mental health problems. More importantly, the projects are measuring the processes being used to provide integrated services in order to understand the role played by specific service designs in program success using a common research design and data collection methodologies.

- HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports projects to develop health care delivery programs and health care services for children in child care programs. It provides the framework and support for newborn screening programs. It also supports the development of coordinated care delivery systems and services for children with special health care needs.

- HRSA – Maternal and Child Health, Healthy Start. HRSA will fund approximately 13 additional new Healthy Start projects targeting communities with high infant mortality and other socioeconomic risk factors. With these additional projects, HRSA will be funding approximately 95 communities (20 mentoring projects and 75 replication projects) to reduce barriers to care, improve perinatal systems, support private sector partnerships that facilitate welfare to work and community job creation, and reduce racial disparity in health status.

- HCFA – Estimates of the insurance coverage of children in the United States suggest that there are approximately 11 million children under the age of 19 who lack insurance. Research shows that children who lack insurance coverage have access to fewer health services. Insured children are more likely than uninsured children to get preventive and primary health care. Insured children are also more likely to have a relationship with a primary care practitioner and to receive basic preventive services, such as immunizations and well-child checkups. Medicaid and the Children's Health Insurance Program (CHIP) have the potential to cover many of the children who currently lack insurance. However, a successful broad-based effort to target and enroll eligible children is required. To ensure that both Medicaid and CHIP fulfill their potential, HCFA is working with the States, other parts of HHS, other Federal government agencies, and the private sector on a broad array of outreach activities. These activities include educating Federal workers, State workers, and grantees about children's health outreach; educating families about their potential eligibility for health insurance; and coordinating efforts across States, community-based organizations, advocacy groups, Government grantees (such as Information, Counseling, and Assistance agencies (ICAs)), and private sector groups.

- CDC – Lead Poisoning. Exposure to lead is a well-recognized cause of serious cognitive, learning, and behavioral problems in children. Progress continues to be made in reducing childhood lead poisoning, but many children nationwide, especially those who live in large central cities in older housing, continue to be heavily exposed to lead from lead-based paint, dust, and soil. Screening and other lead poisoning prevention approaches are being intensified among children in high-risk populations. In order to more effectively focus screening and follow-up efforts on high-risk children, CDC has updated its screening guidelines, based on new scientific and practical information. This will result in better targeting of prevention efforts and enable prevention programs to use their limited resources more cost-effectively.

- HRSA – Universal Newborn Hearing Screening and Early Intervention. This program, in partnership with CDC and NIH, will promote universal newborn hearing screening prior to hospital discharge and link the screening to intervention within the community service system, thereby greatly lowering the age at which children with congenital permanent hearing loss are identified, and increasing the ability of these children to perform on school related measures.

- NIH – Pediatric research represents a longstanding priority area of interest across many of the NIH's Institutes and Centers. NIH pediatric research has resulted in major advances in the understanding, diagnosis, treatment, and prevention of the diseases, disorders, and conditions that affect children through all stages of development. For example, one initiative is to examine the nutrition of very low birth weight (VLBW) infants and early brain development. As VLBW infants develop, they demonstrate a high incidence of low IQ with functional

impairments in mathematics and processing visual material. One suggested reason for these problems is inadequate nutrition at a time when VLBW infants would normally be *in utero*.

Selected FY 2000 Performance Goals and Measures

- To assess outcomes of the Head Start program, ACF is conducting the Family and Child Experiences Survey (FACES). FACES is a longitudinal study of a nationally representative sample of 3200 children and families in 40 Head Start programs that will include assessment of the same children both before and after their Head Start experience as well as after a year of kindergarten.

  From this data, ACF will establish measures and baselines during FY 1999 for goals assessing that children demonstrate improved emergent literacy, numeracy and language skills; improved general cognitive skills; improved gross and fine motor skills; improved positive attitudes toward learning; improved social behavior and emotional well-being; and improved physical health. *ACF Plan*

- Increase from 97% to 100% the number of Head Start grantees serving non-English speaking children which employ staff who speak the same language. *ACF Plan*

- Increase from 90% to 92% the percentage of Head Start grantees which provide special education and related services to disabled children as soon as possible after developing the Individualized Education Plan. *ACF Plan*

- Maintain at 88% the percentage of Head Start children who receive necessary medical treatment after being identified as needing medical treatment. *ACF Plan*

- Increase from an estimated 95% to 100% the number of classroom teachers with a degree in early childhood education (ECE), a child development associate (CDA) credential, a State-awarded preschool certificate, a degree in a field related to ECE plus a State-awarded certificate, or who are in CDA training and have been given a 180 day waiver, consistent with the provisions of Section 648A(a)(2) of the Head Start Act. *ACF Plan*

- ACF and its partners are working to refine and establish baselines for the following proxy child care measures: Increase the number of States that provide health services linkages with care (i.e., immunization, Medicaid outreach, and screening). *ACF Plan*

- Increase the percentage of Medicaid two-year old children who are fully immunized. FY 2000 measure: An initial group of States will measure their immunization rates at the end of FY 2000 using the same methodology they used for their baseline in FY 1999; State-specific numerical targets for immunizations will be established as percentage increases over established baselines, in immunized children 2 years old enrolled in State Medicaid programs. The process will be repeated in a staggered manner for a second and third wave of States beginning in FY 2000 and FY 2001. [Developmental] *HCFA Plan*

- At minimum, achieve the following immunization coverage of at least 90% (baseline 78% in 1996) among children 2 years of age:

  - 4 doses of Diphtheria-Tetanus-Pertussis containing vaccine
  - 3 doses of Haemophilus influenzae type b vaccine
  - 1 dose of Measles-Mumps-Rubella vaccine
  - 3 doses of Hepatitis B vaccine
  - 3 doses of Polio vaccine *CDC Plan*

- During FY 2000, increase by 3% the proportion of AI/AN children who have completed all recommended immunizations by the age two over the FY 1999 rate. *IHS Plan*

- By 2000, the number of children with elevated blood lead levels will have been reduced by 30% over the 1991-1994 baseline of 890,000 children with blood lead levels greater than 10 micrograms per deciliter. *CDC Plan*

- Decrease the number of uninsured children by working with States to implement CHIP and by enrolling children in Medicaid. FY 2000 measure: Increase the number of children less than 21 years of age who are enrolled in Medicaid and number of children less than 19 who are enrolled in CHIP. The baseline measurement will be taken in FY 2000. [Developmental] *HCFA Plan*

- Increase by 25% the utilization of comprehensive community-driven health services in Healthy Start project areas by pregnant/parenting women and infants. Measures under consideration: number of pregnant participants during reporting period; and number of women making postpartum visit within eight weeks of end of pregnancy. [Developmental] *HRSA Plan*

- Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children in order to help implement the State Child Health Insurance Program. FY 2000 measure: 9.025 million clients served in underserved areas. *HRSA Plan*

- By the end of FY 2000, increase by 5% the proportion of AI/AN children served by IHS receiving a minimum of four Well Child Visits by 27 months of age, over the FY 1999 baseline. *IHS Plan*

Programs Supporting This Objective

ACF
Child Care
Head Start
CDC
Immunizations
Lead Poisoning
FDA
Drugs
HCFA
Medicaid
Children's Health Insurance Program
HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant
Healthy Start
Universal Newborn Hearing Screening and

Early Intervention
NIH
Research Program
OPHS
Office of Disease Prevention and Health Promotion, Healthy People 2010
SAMHSA
Knowledge Development and Application

HHS 2.4: Improve the Safety and Security of Children and Youth

From the HHS Strategic Plan, September 1997. The Department is deeply committed to improving the safety and security of children served by the child welfare system. In the past twenty years, social, cultural, and economic changes such as increases in substance abuse, community violence, and poverty have increased the number and severity of family problems. Reports of substantiated, as well as suspected, cases of child abuse and neglect continue to increase. The damaging effects of child abuse and neglect on the physical, psychological, cognitive, and behavioral development of children are well documented.

At the end of 1995, over 450,000 children were in foster care, an increase of almost 42 percent since 1988. While many of these children will return home, nearly 100,000 will not. The median stay in foster care is over two years; and it takes substantially longer to find permanent homes for minority children. Older children, sibling groups, and children with disabilities, irrespective of race, also have longer waits.

Key FY 2000 Activities, Initiatives, and Strategies

- ACF – Adoption and Safe Families Act Programs. The President has set an Adoption 2002 goal of providing safety, permanency and well-being for at-risk children by doubling the number of adoptions and permanent placements from the public welfare system. ACF will continue the joint effort by Federal, State and local governments, child welfare and adoption professionals, community leaders, and interested citizens to achieve this goal, thereby improving the lives of children who are backlogged, or at risk of being backlogged, in the child welfare system, by creating permanent homes for them.

  In addition, efforts to reduce barriers to the adoption process and strengthen ACF's technical assistance to enable States to increase the numbers of children adopted, especially children with special needs will continue. In addition, ACF proposes an investment from title IV-E funds for monitoring of child welfare and family service programs in the states, including family preservation and support, time-limited reunification services, adoption support services, child protective services, foster care, adoption, and independent living. These reviews are essential to safety, permanency and child and family well-being. In addition, these funds will be targeted to providing technical assistance and monitoring of critical systems development, the system which provides ACF with the information necessary to approve or disapprove state expenditures. A legislative proposal will be developed to allow use of funds for these critical activities.

- OCR – Implementation of Adoption Nondiscrimination Requirements. OCR will continue technical assistance to states and placement agencies, ongoing partnership with ACF and others, reviews or investigations of compliance, and follow-up monitoring of corrective action plans associated with implementation of the strengthened adoption nondiscrimination provisions included in the Small Business Job Protection Act of 1996 and in guidelines for OCR and ACF implementation. OCR and ACF are exploring the potential for joint reviews

and for OCR participation in ACF state agency reviews. OCR will increase the number of partnerships, outreach initiatives and reviews of compliance that it can undertake, consistent with its GPRA Annual Performance Plan objectives, to increase the number of state and local agencies and adoption and foster care providers found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act.

- Administration Initiative – Easing the Transition from Foster Care to Self-Sufficient Adulthood. Once they turn 18 years old, foster care youths become ineligible for maintenance payments. Each year, approximately 16,000 youths age out of foster care and 9,000 youths run away from the foster care system. These teens often lack the resources and the support they need to be self-sufficient. Consistent with the Department's efforts to move families from welfare to work, the FY 2000 President's Budget includes a package of legislative proposals aimed at assisting these former foster youths in their transition to living alone. This package proposes $50 million in FY 2000, and $275 million over the next five years. The proposals include increasing funds for the Independent Living Program and the Runaway and Homeless Youth Transitional Living Program, supporting the Living Expenses of Youths in Transitional Living Programs, and providing Medicaid coverage for emancipated youths to age 21.

- ACF – Independent Living Program. This program will help keep children aging out of the child welfare program from becoming homeless, jobless, or drug addicted.

- HRSA – Primary Care, Health Centers. HRSA's Health Centers are implementing a Family Violence Initiative and plan to add parenting classes, home visiting and abuse prevention services in high risk areas.

- HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports injury prevention and domestic violence reduction programs that reduce both accidental and intended injuries, especially to children.

- SAMHSA – The Comprehensive Community Mental Health Services for Children and their Families Program seeks to provide intensive *community-based* services for children with serious emotional disturbances and their families. The program features a broad array of services tailored to meet the needs of the child through an individualized service planning process. In FY 2000, HHS will continue to support and evaluate approximately 50 grants, allowing continued national progress in improving outcomes for a larger number of children with serious emotional disturbances and their families.

- IHS – Prevention, Health Education, and Treatment programs. IHS screens the treatment population for indication for abuse or neglect and assists its partners to engage in community-based prevention initiatives, such as HIV/AIDS risk behavior, violence prevention, child abuse, physical inactivity, alcohol and substance abuse.

Selected FY 2000 Performance Goals and Measures

- Make progress towards doubling the number of adoptions and guardianships for children in the public foster care system between FY 1997 and FY 2002 by increasing adoptions from 31,000 in FY 1997 to 49,000 in FY 2000 and guardianships from 5,000 in FY 1997 to 7,000 in FY 2,000. *ACF Plan*

- Reduce the median length of time between current removal and adoption for all children from 37 months in FY 1997 to 32 months in FY 2000 while simultaneously decreasing the difference in the median length of time between current removal and adoption between white children and African-American children from 12 months in FY 1997 to 9 months in FY 2000, and white children and Hispanic children from 3 months in FY 1997 to 2.5 months in FY 2000. *ACF Plan*

- In order to increase the number of HHS adoption service providers who provide nondiscriminatory placements for minority children, OCR will increase the number of State agencies and adoption agencies (local) found to be in compliance with the nondiscrimination provisions of the Small Business Job Protection Act. FY 2000 measure: 33 corrective actions and no violation findings Baseline: 20 corrective actions and no violation findings FY 98. *OCR Plan*

- Decrease the percentage of children with substantiated reports of maltreatment who have a repeat substantiated report of maltreatment within 12 months from 23% in Calendar Year 1996 to 21% in FY 2000. *ACF Plan*

- Increase to 75% the proportion of ACF-supported youth programs that are using community networking and outreach activities to strengthen services. (1995 baseline: 68%) *ACF Plan*

- Increase to 60% the proportion of youth receiving peer counseling through program services. (1994 baseline: 51%) *ACF Plan*

- Increase to 95% the proportion of youth living in safe and appropriate settings after receiving ACF-funded services (1995 baseline: 93%). *ACF Plan*

- Increase the proportion of Health Center adults with hypertension who report their blood pressure under control. Target: Healthy People 2000 objective of 50 percent. *HRSA Plan*

- Increase the proportion of Health Center users with diabetes who have up-to-date screening of glycohemoglobin. Target: 20 percent of diabetic adults, based on a literature review of mainstream medical practice. *HRSA Plan*

- By the end of FY 2000, 75% of IHS medical facilities with Urgent Care Emergency departments or services will have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (i.e., child, spouse, and/or elderly). *IHS Plan*

- Under the Comprehensive Community Mental Health Services for Children and their Families Program, SAMHSA will measure performance through increased school attendance, improved grades, more stable living arrangement, and improved mental health functioning. (Developmental) *SAMHSA Plan*

Programs Supporting This Objective

ACF
Child Welfare
Youth Programs
Developmental Disabilities
Social Services Block Grant

HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant

IHS
Prevention and Treatment

OCR
Preventing Discrimination in Access to HHS' Services

SAMHSA
Comprehensive Community Mental Health Services for Children and Their Families Program

HHS 2.5: Increase Opportunities for Seniors to Have an Active and Healthy Aging Experience

From the HHS Strategic Plan, September 1997. One of the major successes of the twentieth century is the lengthening of the life span and the improvement in the health of older people. These developments have spurred a sea change in thinking about the elderly: no longer regarded as dependent, they need help only to maintain economically and socially productive lives. This help is central to the Department's strategy for improving the economic and social well-being of all people in the United States.

Key FY 2000 Activities, Initiatives, and Strategies

- AoA – Supportive Services and Senior Centers. Funds for Supportive Services and Senior Centers operate a national network of state, tribal nad local agencies on aging. These agencies plan and develop a comprehensive and coordinated community-based service system. Services include access, such as information and assistance and outreach, and a wide range of in-home and community-based support for older Americans and their families.

- AoA – Congregate and Home-Delivered Nutrition Services. AoA supports congregate and home-delivered meal programs to increase the nutritional intake of at-risk seniors. For home-delivered participants, the availability of short term home-delivered meals has been linked with decreased hospital stays in hospitals and intermediate care facilities.

- HRSA – Primary Care, Health Centers. HRSA's Health Centers have a proven record of expertise in the management of chronic conditions such as diabetes and hypertension affecting the elderly. HRSA is undertaking an initiative to measure and improve quality of care for diabetic patients in over 100 individual centers. In addition, HRSA has launched an initiative to increase the number of Medicare beneficiaries served, with emphasis on managed care and geriatric expertise.

- CDC – Immunizations. The National Immunization Program (NIP) focuses on several major programmatic areas to achieve its goals, including childhood immunization, adult immunization, and global polio eradication. Although NIP has assistance from many partners, State and local health agencies play a primary role in helping NIP carry out its mission in the United States. State and local health agencies use CDC grant funds for a wide range of activities including hiring staff, conducting surveillance, assessing immunization levels, developing immunization registries, conducting education and outreach, and establishing partnerships with community groups and private sector organizations.

- CDC – Injury Prevention and Control. CDC provides national leadership for designing programs to prevent premature death and disability and reduce human suffering and medical costs caused by injuries. Work in the area of suicide prevention among our Nation's elderly is ongoing, as are efforts to improve institutional and community living environments for the elderly as a means to reduce the risks and consequences of falls.

SAMSHA – Recognizing that most older adults receive mental health and substance abuse (primarily alcohol related) services in a primary care setting, the three SAMHSA Centers, in collaboration with HRSA, will be working to identify the differences in outcomes between models using a referral approach to providing speciality MH/SA services and an integrated approach to providing such services within the primary care setting itself. The study will look at how the location, type of provider, and type of health care financing affects the level of actual use of substance abuse prevention services.

AHCPR – Efforts to assess the quality of care given to elderly populations have a different focus than efforts to measure quality of care for the population at large. Much of this difference stems from the fact that care provided to elderly patients is often aimed at maintaining or improving functioning rather than curing disease. As a result, long-term care outcome measures generally focus on assessing patients' ability to function rather than on ascertaining the presence or absence of disease. In FY 2000, AHCPR will engage in several activities related to improved functioning, including: 1) new research on conditions of particular importance to the Medicaid population; 2) development of tools to measure the quality of care in institutional settings, including patient's experiences with that care; and 3) demonstrations to improve the quality of transitions between settings of care, including acute and long-term care settings.

HCFA – One of HCFA's central concerns is that Medicare beneficiaries are able to get the care they need when they need it, and that they are not impeded by factors such as cost, health status, location, or availability of primary care physicians or specialists. This is true not only for beneficiaries as a class, but most especially for vulnerable subgroups such as persons with disabilities and members of minority and economically disadvantaged populations. Although Medicare provides beneficiaries with a basic set of health benefits, they still are required to pay a significant amount out-of-pocket for premiums, deductibles, and co-insurance. This cost can be prohibitive for many beneficiaries, particularly for the approximately 12 percent who do not have private or public supplemental insurance. HCFA's access to care performance goal will target financial barriers to care for these beneficiaries. Emphasis in the initial years of this multi-year goal will be on increasing enrollment for the Medicare beneficiaries who are eligible for the Qualified Medicare Beneficiary (QMB) or the Specified Low-Income Medicare Beneficiary (SLMB) programs.

HCFA – Medicare has provided access for beneficiaries to mainstream health care. The health care system is changing dramatically with growth in health maintenance organizations and other forms of managed care as well as new delivery arrangements. HCFA's goal is to ensure that all Medicare beneficiaries have a choice of a number of high quality health care options in both fee-for-service and managed care. Three strategies will create greater choice of health plans for Medicare beneficiaries. 1) The Balanced Budget Act of 1997 will allow contracting with other than traditional HMOs. Many of the applications may come from rural areas that have few or no managed care options. In addition, payment changes under the Balanced Budget Act of 1997 will also encourage managed care options in rural areas. 2) Utilization of a "triage" approach will facilitate processing of managed care applications and service area expansions from plans that will offer products in areas that have little or no managed care

penetration. 3) The offering of different plan choices through demonstration projects, such as Choices, Social/HMO, and ESRD capitation demonstration. These allow promotion of managed care in areas that have not had much interest from traditional HMOs.

IHS – Reducing the Gap in Health Disparities Initiative. IHS will target segments of the population that are particularly vulnerable to disproportionate disease burden: children and youth, women, elders, and urban Indians. IHS will also target the specific disease entities identified as priority areas and responsible for much of the disparity in health status for the AI/AN population.

NIH – The National Institute on Aging's Edward R. Roybal Centers of Research on Applied Gerontology conduct research with the goal of keeping people independent, active, and productive in later life. Investigators at these centers focus on translating promising social and behavioral research findings into strategies to help improve the lives of older people and their families in such areas as computer skills, driving, exercise, caregiving, and nursing home care.

AoA – Grants to Indian Tribes. Grants to Indian Tribes and Native Hawaiian Organizations provides funding to Indian tribal organizations, Alaskan Native organizations, and non-profit groups representing Native Hawaiians to provide supportive and nutrition services, including both congregate and home delivered meals to older Native Americans.

OPHS – Activities and initiatives on cardiovascular disease, the prevention of osteoporosis, a new older women's exercise and fitness initiative, and related activities are targeted at health promotion and disease prevention for women.

Selected FY 2000 Performance Goals and Measures

♦ Secure and maintain access to aging-related services and opportunities for older individuals and their families through the Older Americans Act and other funding sources. FY 2000 measures: Maintain level of service provision at 2,976,149 hours of case management; 12,526,537 information and assistance contacts; and 39,496,946 one-way rides. *AoA Plan*

♦ The Older Americans Act puts in place a nationwide service delivery system, the aging network, which coordinates funding streams into a comprehensive services system. Therefore, AoA uses the proportion of "leveraged" funding as a performance indicator for its community-based services.

FY 2000 measures: One percent increase in leveraged funding for information and assistance services, $381,054; transportation services, $953,497; and case management services, $646,226. *AoA Plan*

♦ Prevent decline and/or improve nutritional intake of home-delivered participants. FY 2000 measure: Increase in the number of home-delivered meals served to 146 million meals above the 1996 baseline of 119 million meals. *AoA Plan*

- Prevent decline and/or improve nutritional intake of congregate meal program participants. FY 2000 measures: Maintain level of service provision at 118.6 million congregate meals. Maintain number of program participants at 2,147,756. *AoA Plan*

- Improve the health and well-being, and reduce social isolation of older American Indians, Alaska Natives, and Native Hawaiians through the provision of community-based services. FY 2000 measure: Maintain service provision at the level in Fiscal Year 1995. *AoA Plan*

- The rate of pneumococcal pneumonia and influenza vaccination among persons ≥65 years will be increased to 60% for influenza and to 60% for pneumococcal pneumonia. Baseline: Influenza: 58% (1995); Pneumonia: 32% (1995) *CDC Plan*

- By the end of 2000, increase the overall pneumococcal and influenza vaccination levels among adults age 65 and older to 60%. *IHS Plan*

- In collaboration with States and the advocacy community, HCFA we will implement the strategy for increasing enrollment of the dual eligible population in the QMB and SLMB programs. HCFA will meet the enrollment target that was established as part of the FY 1999 performance plan and work in collaboration with States to determine enrollment targets for FY 2001 and beyond. [Developmental] *HCFA Plan*

- HCFA will ensure that in FY 2000, 80% of medicare beneficiaries have at least on managed care choice. *HCFA Plan*

- By the end of FY 2000, 75% of IHS medical facilities with Urgent Care Emergency departments or services will have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (i.e., child, spouse, and/or elderly). *IHS Plan*

Programs Supporting This Objective

AHCPR
Research on Health Costs, Quality, and Outcomes
AoA
Supportive Services & Centers
Congregate Meals
Home-Delivered Meals
In-home Services, Frail Elderly
Preventive Health Services
Alzheimer's Initiative

HRSA
Primary Care, Health Centers
IHS
Grants to Indian Tribes
CDC
Immunization
Injury Prevention and Control
HCFA
Medicare
Peer Review Organizations
Medicare+Choice
Medicaid

Treatment and Prevention
NIH
Research Program
OPHS

Healthy People 2000
Office on Women's Health
SAMHSA
Knowledge Development and Application
Targeted Capacity Expansion
National Data Collection State Infrastructure
Protection and Advocacy
Mental Health Performance Partnership
Block Grant
Substance Abuse Block Grant

HHS 2.6: Expand Access to Consumer-Directed, Home and Community-Based Long-Term Care and Health Services

From the HHS Strategic Plan, September 1997. According to the recent *Disability Supplement to the National Health Interview Survey*, disability is widespread in America: 19.1 million people report that they perceive themselves or others perceive them as having a disability, 16.9 million report a disability that limits or prevents them from working, and 13.8 million receive benefits from a disability program. (These groups overlap.)

Although most seniors are active, older people have greater needs for health and long-term care. Because of advanced age or severe disability, many are dependent on others for even basic needs—bathing, dressing, getting in and out of bed, using the toilet, shopping, managing money, doing housework, or simply using the telephone.

Although disability and the need for long-term care increase substantially with age, they do not concern solely the elderly. Of those who need long-term care, half are under age 65. According to recent analyses of the *1994 Disability Supplement to the National Health Interview Survey*, 5.3 million working-age adults need help with one or more of their daily living activities. Furthermore, people with disabilities are less likely to be employed than are their counterparts without disabilities. To become employed and maintain employment, people with severe disabilities need both supports in their daily living activities and access to health insurance to meet their medical needs.

As the baby boom generation ages, the proportion of the population likely to need long-term care will expand and the demand for long-term care and health services likely will do so as well. Meeting this demand is a critical factor if we are to help the elderly and working-age adults obtain and keep jobs or continue to be socially integrated into their communities.

Still another problem needs to be addressed as part of the demand for services. While increasing numbers of seniors and working-age adults with disabilities are getting long-term care in community-based settings, many are still served in nursing homes and other public and private institutional settings. In general, people with disabilities and their families and friends advocate minimizing reliance on institutional care and maximizing use of services in home and community-based settings they themselves help direct. Although all the states have responded by creating Medicaid waiver programs that provide these services, and many are experimenting with new ways to afford greater consumer control in personal assistance services, more needs to be done to offer long-term supports in community settings in which consumers have a role.

Key FY 2000 Activities, Initiatives, and Strategies

- Administration Initiative – Supporting Retirement with Dignity. This multi-part initiative addresses the daily needs of our Nation's steadily growing elderly population:

National Family Caregiver Support Program. HHS proposes $125 million in FY 2000 to serve approximately 250,000 families nationwide with this new program. This initiative provides for basic support services for caregivers, such as counseling and training, respite care, home health services, and referral. The initiative supports families who care for elderly relatives with chronic illnesses or disabilities by enabling States to create "one-stop shops" which provide quality respite care, information about community-based long-term care services, and counseling and support, including training for complex care needs.

Long-Term Care Information Campaign. Nearly 60 percent of Medicare beneficiaries are unaware that Medicare does not cover most long-term care services. Furthermore, many are unaware which services may best meet their needs. The HHS budget proposes a $10 million nationwide campaign to provide all 39.8 million Medicare beneficiaries with relevant information regarding Medicare covered services, how to identify quality private long-term care, and how to access information about home and community-based care services.

Expansion of Home and Community-Based Options. This initiative gives States the option of expanding Medicaid eligibility for people with incomes up to 300 percent of the Supplemental Security Income level who meet nursing home eligibility requirements but want to live in their communities. This initiative costs $5 million in FY 2000, for a total of $110 million over five years.

Nursing Home Quality Initiative. The HHS FY 2000 budget includes $60 million to implement the President's Nursing Home Initiative announced in July, 1998. In FY 1999, HHS began phasing-in key provisions of the initiative. This budget request allows the Health Care Financing Administration (HCFA) and other components of the Department to fully implement all provisions of the President's initiative. Funding will be provided for State surveys of nursing homes, Federal surveyor oversight and developing a national criminal abuse registry to screen potential nursing home employees. These funds will also ensure adequate legal resources for the Office of the General Counsel and the Departmental Appeals Board to provide judicial hearings and handle administrative and court litigation in a timely manner.

AoA – Congregate and Home-Delivered Nutrition Services. AoA supports congregate and home-delivered meal programs to increase the nutritional intake of at-risk seniors. For home-delivered participants, the availability of short term home-delivered meals has been linked with decreased hospital stays in hospitals and intermediate care facilities.

AoA – Long-Term Care Ombudsman. States will be encouraged to develop targeted ombudsman program strategies which are prevention and public health education oriented. Data from the National Ombudsman Reporting System will be used to identify the quality of care problems that can be averted through preventive interventions.

AOA – National Family Caregiver Support Program. Via formula grants to States, this proposal calls for the creation of a multi-faceted support system that provides: 1) information to caregivers about available services; 2) assistance with access to services: 3) individual counseling and the organization of support groups to help families make decisions and solve problems related to their caregiving roles; 4) respite care in the home, in adult day care

centers, and in residential settings; and 5) direct services available on a limited basis to complement the informal care provided by families.

Additionally, the proposal calls for innovation incentive grants to foster the development and testing of evidence-based approaches for; e.g., optimizing the likelihood of rehabilitation, behavioral modification and management, and/or caregiver stress reduction.

- AoA – Alzheimer's Initiative. AoA will test innovations in the provision of assistance to persons with Alzheimer's Disease and their caregivers.

- HCFA - States have the option of providing Medicaid coverage for categorically related groups, such as individuals who would be eligible for Medicaid if institutionalized, but who are receiving care under home and community-based services waivers. The Balanced Budget Act made permanent the Programs of All-inclusive Care for the Elderly (PACE), for eligible persons as a State option. PACE provides an alternative to institutional care for persons aged 55 and over who require a *nursing facility level* of care. The PACE team offers and manages all health, medical, and social services, and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive services. This care is provided in day health centers, homes, hospitals, and nursing homes--while helping the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well as under Medicaid. PACE providers must make available all items and services covered under both Medicare and Medicaid without amount, duration, or scope limitations, and without application of any deductibles, copayments, or other cost sharing.

- SAMHSA - The Center for Mental Health Services, working in partnership with other Federal agencies, State and local mental health authorities, service providers, consumers of services, and their families, plays a pivotal role in guiding a system of care for community based, consumer focused services. An example is the recently funded knowledge development program on the Effectiveness of Consumer Operated Services.

- AHCPR – Efforts to assess the quality of care given to elderly populations have a different focus than efforts to measure quality of care for the population at large. Much of this difference stems from the fact that care provided to elderly patients is often aimed at maintaining or improving functioning rather than curing disease. As a result, long-term care outcome measures generally focus on assessing patients' ability to function rather than on ascertaining the presence or absence of disease. In FY 2000, AHCPR will support the Secretary's long-term care initiative with several activities, including: 1) new research on conditions of particular importance to the Medicaid population; 2) development of tools to measure the quality of care in institutional settings, including patient's experiences with that care; and 3) demonstrations to improve the quality of transitions between settings of care, including acute and long-term care settings.

- OCR – Preventing Discrimination in Access to HHS' Services. When providers seek Medicare certification, OCR conducts a pre-grant review to determine whether they will be able to comply with Title VI, Section 504, and the Age Discrimination Act. Such reviews are an effective means for working with health care providers because potential civil rights

concerns can be identified prior to receipt of federal financial assistance. With the technical assistance that accompanies these reviews, health care providers can take steps to avoid future allegations of discrimination.

Selected FY 2000 Performance Goals and Measures

- Assist residents, families, friends and others to resolve problems related to care and conditions in long-term care facilities. FY 2000 measure: Maintain 71.48% national resolution/partial resolution rate. *AoA Plan*

- Strengthen the roles of family caregivers by providing access to counseling and services which help to lessen their physical and emotional burden of caring for cognitively and physically impaired older persons. FY 2000 measure: Conduct a survey of caregivers and older persons receiving care, using statistically valid random sampling methods, to provide data for establishing baseline and target. *AoA Plan*

Programs Supporting This Objective

AHCPR
Research on Health Costs, Quality, and Outcomes
AoA
Supportive Services & Centers
Congregate Meals
Home-Delivered Meals
Preventive Health Services
Alzheimer's Initiative
Long-Term Care Ombudsman
Grants to Indian Tribes
HCFA
Medicaid
Medicare
OCR
Preventing Discrimination in Access to HHS' Services
SAMHSA
Knowledge Development and Application

HHS 2.7: Improve the Economic and Social Development of Distressed Communities

From the HHS Strategic Plan, September 1997. Whatever their own circumstances, families need strong neighborhoods and communities to create a healthy environment for their children. Not surprisingly, research reveals a significant relationship between the quality of community life and the individual well-being of its residents. Residency in economically distressed neighborhoods can mean poor early childhood development, lower educational attainment, and poor health indicators, as well as higher rates of violence, infant mortality, substance abuse, and teen parenthood.

Vibrant communities provide economic opportunity and social support—jobs, education, health, housing, and safety, the conditions in which initiative, work, and stable families can flourish.

Key FY 2000 Activities, Initiatives, and Strategies

- Comprehensive, Coordinated Community Services. HHS's community service programs, such as ACF's Family Violence Prevention Program, Community Services Block Grant, Healthy Start, SAMHSA's Mental Health Services for Children, and AoA's Aging Network are encouraged to build coordinated service networks.

- Community Involvement. HHS promotes the involvement of community residents as active partners in developing and implementing local programs and services through community service programs, such as ACF's Community Services Block Grant Program and Native American Programs and CDC's HIV prevention programs.

- ACF – The Empowerment Zone/Enterprise Community. The EZ/EC initiative, in cooperation with the Department of Housing and Urban Development, provides substantial funding and technical assistance for community development corporations and other organizations to create new business and employment opportunities.

- ACF – Temporary Assistance for Needy Families. TANF promotes work, responsibility and self-sufficiency and strengthens families through funding of State-designed and -administered programs that provide support to needy children and move their parents into work.

- ACF – Community Services Block Grant. CSBG provides a range of services and activities having a measurable and potentially major impact on causes of poverty in the community.

- ACF – Social Services Block Grant. SSBG supports a variety of social services tailored to supplement State investments in the self-sufficiency and well-being of low income populations through State grants. SSBG funds also help improve and integrate services, create community-based partnerships, and stimulate innovations.

- ACF – Native American Programs. ACF's Social and Economic Development Strategies program is based on the premise that local communities have the primary responsibility for determining its own needs, planning and implementing its own programs, and for use of its own natural and human resources. Through a direct grant funding relationship, Tribes and Native communities have created administrative systems to operate their own social and economic programs, much in the same way as State and local governments. Support for the unique, government to government relationship that exists between Tribal governments and the Federal government is reflected in this approach. Additional priority funding areas include native languages preservation and enhancement, environmental regulatory enhancement, and environmental mitigation.

- HRSA – Primary Care, Health Centers. HRSA's Health Centers provide economic development in the communities they serve, providing jobs for neighborhood residents and business for local enterprises. Many are participating in the Empowerment Zone/Enterprise Community program through ACF and the Department of Housing and Urban Development.

- HRSA – Healthy Start. HRSA will fund approximately 13 additional new Healthy Start projects targeting communities with high infant mortality and other socioeconomic risk factors. With these additional projects, HRSA will be funding approximately 95 communities (20 mentoring projects and 75 replication projects) to reduce barriers to care, improve perinatal systems, support private sector partnerships that facilitate welfare to work and community job creation, and reduce racial disparity in health status.

- ACF – Low-Income Home Energy Assistance. LIHEAP block grants provide funds to States, Indian Tribes/Tribal organizations and Insular areas to assist low-income households in meeting the costs of home energy.

- IHS – Division of Facilities and Environmental Engineering. IHS provides access to health services through construction of health care and sanitation facilities.

- CDC – HIV/AIDS Prevention. The largest portion of CDC's HIV prevention resources is awarded to state, local, and territorial health departments. Priorities for these resources are determined through the HIV prevention community planning process. This process brings together representatives of affected and HIV-infected populations with health department officials, scientists, and service providers to analyze the epidemic in their jurisdiction, assess prevention needs, develop resource inventories, identify priority needs in terms of populations and the most effective interventions to reach each population, and develop a comprehensive plan for HIV prevention in the jurisdiction that reflects the established priorities.

- SAMHSA – CSAP's State Incentive Grant (SIG) Program will enable Governors/States to examine their State Prevention Systems and redirect resources to critical targeted prevention services within their states. Eighty-five percent of the SIG funds will be directed toward communities for implementing best practices and improving the access/quality of services.

- OPHS – Through its staffing of the Departmental Minority Initiatives Coordinating Committee (DMICC), OPHS will guide and coordinate the formulation of action plans for the

implementation of the four minority-specific initiatives, which encompass Blacks/African Americans, Hispanic/Latinos, American Indians/Alaska Natives, and Asian Americans/Pacific Islanders. While necessarily diverse in their scope and goals, these initiatives share common aims at improving institutional infrastructure and educational outcomes for disadvantaged minorities.

Selected FY 2000 Performance Goals and Measures

- As part of the ongoing work with partners, an extensive set of goals and measures relevant to individuals, families, communities, agencies, and partnerships is under discussion. Sample measures under development for ACF's "community revitalization" goal include: Increase the number of participants enrolled in educational and literacy programs who attend regularly; and increase the amount of property tax generated as a result of rehabilitation projects. *ACF Plan*

- Increase by 3% the number of volunteer hours contributed by CSBG consumers in one or more community groups. 1996 baseline estimate: 24.3 million hours *ACF Plan*

- Increase by 4% the amount of non-Federal resources brought into low-income communities by the Community Services Network (non-Federal funds mobilized). 1996 baseline: $1.206 billion *ACF Plan*

- To assess its goal to increase the capacity-building and infrastructure development for tribes and organizations, particularly through the development of codes, courts systems, and the revision of existing Tribal constitutions, ACF will develop a baseline and measure for capacity-building and infrastructure development objectives. *ACF Plan*

- Maintain at the FY 1997 baseline of 1614 visits the annual number of site visits by Tribal T/TA contractors to the diverse Native American population, with particular emphasis on urban Native organizations, rural and non-Federally recognized Tribes. *ACF Plan*

- The Capital Improvement/infrastructure prevention program is an integral part of IHS through providing safe water and waste water services to Indian communities. By the end of FY 2000, provide sanitation facilities projects to serve 4,300 new or like-new homes and 11,530 existing Indian homes. *IHS Plan*

- Improve critically needed access to health care services by completing construction of the Hopi (Polacca), Arizona Health Center; continuing construction of the Ft. Defiance, Arizona Hospital; beginning construction of the Parker, Arizona Health Center; completing the designs of facilities at Winnebago, Nebraska; Pinon, Arizona; Red Mesa, Arizona; Pawnee, Oklahoma; and the St. Paul, Alaska facility; constructing a satellite Youth Regional Treatment Center in Gardnerville, Nevada; providing new or replacement dental units; initiating Joint Venture projects with tribes; and providing Small Ambulatory Care Facility Grants to tribes by the end of FY 2000. *IHS Plan*

Programs Supporting This Objective

ACF
Community Services Block Grant
Family Violence Prevention Programs
Low-Income Home Energy Assistance
Native American Programs
Social Services Block Grant
CDC
HIV/AIDS Prevention
HCFA
Medicaid
Medicare

HRSA
Primary Care, Health Centers
Healthy Start
IHS
Division of Facilities and Environmental Engineering
OPHS
SAMHSA
State Incentive Grants

HHS Goal 3: IMPROVE ACCESS TO HEALTH SERVICES AND ENSURE THE INTEGRITY OF THE NATION'S HEALTH ENTITLEMENT AND SAFETY NET PROGRAMS

From the HHS Strategic Plan, September 1997. The estimated 40 million Americans who lack any health insurance coverage, and the even larger number who are without insurance for behavioral health care services, are at serious risk of going without essential health care. It is a matter of grave concern that these already large numbers are rising, and that employment-based insurance—the bedrock of coverage for working Americans—is declining. The percentage of the nonelderly population with employment-based health insurance coverage shrank from 69.2 percent in 1987 to 63.8 percent in 1995. Without insurance, access to health services, particularly primary and preventive services, is severely compromised. Other barriers to access include the absence of health care facilities or professionals; discrimination on grounds of race, national origin, age, or disability; and language or cultural obstacles that impede the delivery of care.

The major federal programs are the mechanisms through which the Department provides access to care: Medicare and Medicaid, the new State Children's Health Insurance Program, the Indian Health Service (IHS), and the safety net programs (Community Health Centers, Ryan White Care Program, Substance Abuse and Mental Health Block grants, Maternal and Child Health Program). All are undergoing changes that affect access. The agents of change include the emergence of managed care, demographic trends, changes in the relations among the country's levels of government, and the expanding numbers of uninsured individuals who depend on the safety net programs.

The Department is equally committed to the sound and fiscally prudent management of all of these programs. Because of their size and scope, the Medicare and Medicaid programs are particular targets for fraud and abuse and accordingly receive the highest-priority attention. A coordinated enforcement effort—modeled on the highly successful Operation Restore Trust and involving multiple components of the Department of Health and Human Services (HHS), as well as the Department of Justice (DOJ)—is expected to curb strictly and severely fraud and abuse in these programs. Areas of concern encompass fraud perpetrated by providers and beneficiaries as well as program payment policies that may reimburse excessively for certain types of services, and management practices that are wasteful or inefficient. The Department's program strategy targets all of these.

The Department's strategy has three components. First, HHS will work with the Congress and the states to broaden access to services by enlarging the percentage of children and adults who have health insurance coverage. Second, the Department will maximize the number of low-income or special-needs populations served through its programs, consistent with the level of appropriations to those programs. Emphasis will be on integrating specialized safety net pro

grams with Medicare and Medicaid. Third, HHS will expand its efforts to prevent waste, fraud, and abuse in all of its programs—but particularly in Medicare and Medicaid because of their size and their impact on the total health care system.

HHS 3.1: Increase the Percentage of the Nation's Children and Adults Who Have Health Insurance Coverage

From the HHS Strategic Plan, September 1997. Medicaid insures low-income and severely disabled children. Almost 21 million children receive health coverage through Medicaid, which provides care for nearly 33 percent of the nation's infants and for the overwhelming majority of all children with HIV/AIDS. Nonetheless, over 10 million children remain without any form of coverage. These children and their families are commonly the working poor, and many rely upon federally funded clinics or emergency rooms for both their primary and their acute health care needs. Children without health insurance or a regular source of health care suffer a higher frequency of acute medical conditions and other preventable illnesses.

In addition, individuals may face various forms of discriminatory practices by health insurers or managed care plans due to pre-existing conditions (including genetically identified vulnerabilities, a history of mental illness, or substance abuse), disability, job transitions, or personal factors. These discriminatory practices worsen the percentage of children and adults who are uninsured.

Key FY 2000 Activities, Initiatives, and Strategies

Administration Initiative – Providing Quality, Affordable Health Care for America's Working Families. This initiative expands access to health care for vulnerable groups:

Increasing Health Care Access for The Uninsured. HHS' goal is to provide basic care at the right time and the right place for those who need it. Nearly 43 million Americans lack medical coverage. This $1 billion investment spread over 5 years will improve medical care for many of the Nation's uninsured adults by encouraging collaboration between primary care providers and hospitals to ensure that patients receive appropriate treatment. Ultimately, this initiative will provide approximately 100 grants to communities to assist them in organizing and delivering health care to the Nation's growing cadre of low-income workers and others who lack health insurance. This initiative also will help communities acquire basic health services which are often in short supply for the uninsured. It encourages collaborations among local health departments, independent community health centers, public hospitals and hospitals affiliated with medical schools.

Medicare Buy-In for Displaced Workers. The FY 2000 budget allows displaced workers over age 55 access to Medicare by offering those who involuntarily lose their jobs and health insurance a buy-in option. This initiative costs a net of $0.1 billion over five years, although these costs are offset by proposed Medicare savings in the FY 2000 budget.

Expanding Opportunities For the Working Disabled. The President commits $20 million in FY 2000 and $857 million over five years in Medicare and Medicaid spending to support opportunities for people with disabilities to return to work without losing their health care. The initiative increases flexibility for States to set higher income and resource standards for Medicaid. It also provides incentive grants to States to expand Medicaid coverage for the

working disabled and to build the capacity to provide home and community based services in order to provide an alternative to institutional care. In addition, the initiative would allow people with disabilities who leave Social Security Disability Insurance in the next 10 years to go to work but continue receiving free Medicare Part A coverage.

Medicare Buy-In for Early Retirees. The FY 2000 budget enables Americans aged 62-65 to buy into Medicare by paying a full premium and extends the option of coverage until age 65 for those workers whose companies terminated retiree health coverage. This initiative costs a net of $1.3 billion over five years, although these costs are completely offset by proposed Medicare savings in the FY 2000 budget.

HCFA – Children's Health Insurance Program. Through the Balanced Budget Act of 1997, the President and Congress established the Children's Health Insurance Program (CHIP) and allocated $24 billion through 2007 to extend health coverage to uninsured children. To ensure that the Children's Health Insurance and Medicaid Programs fulfill their potential in this regard, HCFA is working with the States, other parts of HHS, other Federal agencies, and the private sector on a broad array of outreach activities to reach uninsured children. These activities include educating Federal workers, State workers and grantees about children's health outreach, and educating families about their potential eligibility for health insurance. It also includes coordinating efforts across States, community-based organizations, advocacy groups, Government grantees, such as Information, Counseling, and Assistance Agencies (ICAs), and private sector groups to identify or establish networks, coalitions and partnerships that can play an instrumental role in the development and implementation of outreach and enrollment strategies for both Medicaid and CHIP populations.

Administration Initiative – CHIP and Medicaid Outreach. This outreach initiative informs children and their caregivers about CHIP and Medicaid, and gives States flexibility to provide innovative and effective approaches to increasing outreach activities.

HCFA – The Health Insurance Portability and Accountability Act (HIPAA) was enacted to promote access to health insurance coverage to people who had lost their insurance, often through job dislocation, or who were previously uninsurable because of their health status. HHS, through HCFA, is responsible for ensuring that States enforce HIPAA provisions with respect to issuers of coverage in the group and individual markets. One real-world way to assess HIPAA implementation is by tracking and analyzing complaints received by HCFA Central and Regional Offices in terms of volume, nature of the complaints, and disposition. Under contract, HCFA will collect the necessary information to track performance in this manner, and will then develop a plan for creating experience-based, quantifiable performance standards.

HCFA – A central concern of HCFA is that Medicare beneficiaries are able to get the care they need when they need it, and that they are not impeded by factors such as cost, health status, location, or availability of primary care physicians or specialists. This is true not only for beneficiaries as a class, but most especially for vulnerable subgroups such as persons with disabilities and members of minority and economically disadvantaged populations. HCFA's goal with regard to this concerns is to improve access to care for elderly and disabled

Medicare beneficiaries who do not have public or private supplemental insurance. In the initial years of its endeavor toward this goal, HCFA will concentrate on enrollment of individuals who are eligible for the Qualified Medicare Beneficiary (QMB) or the Specified Low-Income Medicare Beneficiary (SLMB) programs. These programs were enacted to help low-income Medicare beneficiaries with their Medicare cost-sharing expenses. States are required to pay for the premiums, deductibles, and cost sharing for QMBs, and the Part B premium for SLMBs. Despite the existence of these programs, it has been documented that a substantial proportion of individuals eligible for these programs are not enrolled. (For example, two recent studies estimated non-participation rates for QMB to range from 40 to 60 percent.)

- HCFA – As evident in the previous initiative, individuals who are dually eligible for Medicare and Medicaid are an important and growing segment of beneficiaries. Through continued innovation and reform in the Medicare and Medicaid programs, HCFA hopes to foster a service delivery system that is better integrated and more flexible in meeting the needs of dually eligible beneficiaries. The joint Federal and State interest in dual eligibles has resulted in an examination of the data that are available to obtain knowledge about the demographic characteristics, health status, disease episodes, support services, health services utilization, and expenditures of this diverse population. In response to a need to develop demonstration waiver initiatives to serve dually eligible beneficiaries, 12 individual State-wide Medicare/Medicaid linked data files have been constructed. Primarily, the States are using these data to conduct research and to support the implementation of demonstrations that will in turn lead to improvements for dually eligible beneficiaries.

- HRSA – Primary Care, Health Centers. HRSA's Health Centers will undertake outreach incentives and enrollment assistance to the uninsured who are eligible for coverage under the State Child Health Insurance Program or Medicaid. Centers in a significant number of States are already participating in an Outstationed Eligibility Demonstration in collaboration with HCFA. These and other outreach efforts will be extended in FY 2000.

- HRSA – Maternal and Child Health, Healthy Start. HRSA, in collaboration with States, will intensify its technical assistance to the Healthy Start projects to facilitate training of project staff and community residents on outreach, education, eligibility assessment, and enrollment activities. In addition, the Healthy Start projects will support the monitoring of quality of services provided under CHIP and serve as advocates in breaking down barriers to care for families.

- OCR – Preventing Discrimination in Access to HHS' Services. During FY 1998, OCR worked with HCFA and HRSA staff in reviewing initial state CHIP plan proposals, noting problems with regard to enrollment, outreach, provision of services, availability of materials, and site accessibility for persons with visual and hearing disabilities and persons with limited English proficiency. OCR plans to follow up with state agencies as they implement their plans to ensure that they incorporate methods of program administration that guarantee effective civil rights protection for program participants, including nondiscrimination policies, grievance and complaint procedures, translation of important program documents, use of systems for identifying interpreter services and auxiliary aids needed by clients and their families, and

training of employees on Title VI and Section 504/ADA requirements. In addition, by FY 2000, OCR anticipates conducting post-grant reviews and investigations where information has come to our attention that compliance problems may exist.

OPHS – OPHS provides policy analysis and OPHS' perspective on a wide-variety of issues associated with the implementation of the State Child Health Insurance Program and Child Health Initiative.

Selected FY 2000 Performance Goals and Measures

♦ Improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance. FY 2000 measure: HCFA, States and advocacy community will meet the QMB and SLMB enrollment targets established under its FY 1999 activity for this goal. [Developmental] *HCFA Plan*

♦ Develop a performance goal concerning HIPAA effectiveness in resolving complaints against insurers. FY 2000 measure: Complete the development of a performance goal and targets to be included in future performance plans. [Developmental] *HCFA Plan*

♦ Provide to States linked Medicare and Medicaid data files for dually eligible beneficiaries. FY 2000 measure: Provide linked identifiers for 49 States, develop fully integrated files for a number of States (to be determined), and provide analytical tools to the States for improving use of the data. *HCFA Plan*

♦ Increase community and provider understanding of the State CHIP and its eligibility requirement, provider location, service reimbursement and relevant issues. Perform CHIP outreach, enrollment, consumer advocacy and support quality monitoring functions at all Healthy Start sites. FY 2000 measure: Number of projects reporting involvement in CHIP activities such as provider training, outreach, enrollment, and consumer advocacy. [Developmental] *HRSA Plan*

♦ Decrease the number of uninsured children by working with States to implement CHIP and by enrolling children in Medicaid. FY 2000 measure: Increase the number of children less than 21 years of age who are enrolled in Medicaid and number of children less than 19 who are enrolled in CHIP. The baseline measurement will be taken in FY 2000. [Developmental] *HCFA Plan*

♦ Utilizing the State reporting system under the Maternal and Child Health Block Grant, monitor and work to decrease the percent of children without health insurance. [Developmental] *HRSA Plan*

♦ Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children in order to help implement the State Child Health Insurance Program. FY 2000 measure: 9.025 million clients served in underserved areas. *HRSA Plan*

Programs Supporting This Objective

HCFA
Medicare
Medicaid
Children's Health Insurance Program
Health Insurance Portability and Accountability Program

Maternal and Child Health, Healthy Start
Community Health Centers

OPHS
Office of Disease Prevention and Health Promotion

HHS 3.2: Increase the Availability of Primary Health Care Services

From the HHS Strategic Plan, September 1997. An estimated 43 million people confront obstacles to primary care due to the limited numbers of primary health care sites and providers, discrimination**,** and language and cultural impediments. These problems are especially rife in economically disadvantaged neighborhoods and rural areas. A further problem has been the difficulty of integrating appropriate services for mental health and addictive disorders into primary health care and insurance programs.

Key FY 2000 Activities, Initiatives, and Strategies

HRSA – Primary Care, Health Centers and the National Health Service Corps. HRSA's Health Centers and the National Health Service Corps form a cost effective, integrated safety net for underserved and uninsured children, adults, migrant workers, homeless individuals, public housing and U.S./Mexico border residents in approximately 4,000 communities across the country and will serve 10.9 million persons in FY 2000 who would otherwise lack access to a primary care providers. This community-based network delivers preventive and primary care services for the neediest, poorest and sickest patients in rural and inner city areas, through a Federal, State and community partnership approach. FY 2000 strategies focus on:

Access. HRSA will develop additional primary care access points and serve approximately 9.025 million persons in FY 2000, an increase of 125,000 over FY 1999. HRSA will specifically target:

- areas with large numbers of uninsured persons,
- areas of highest need that have, for example, short life expectancy or high infant mortality, such as sections of the southeastern area of the United States,
- areas along the United States/Mexico border, and
- areas where school-based centers, linked with Health Centers, would increase access to health care for vulnerable children.

Racial Disparities. In FY 2000, HRSA will augment Health Center services to focus on disparity reduction, particularly for those communities with the highest morbidity and mortality rates for minority populations. Health Centers will significantly expand and improve current health disparity reduction efforts that are reducing hospitalization and emergency room use, reducing annual Medicaid costs, and helping to prevent more expensive chronic disease and disability.

HRSA – Maternal and Child Health Block Grant. The MCH Block Grant allows States to use appropriated, formula grant funds for resource development, capacity and systems building, and population-based functions such as public information and education, knowledge development, outreach and program linkage, technical assistance to communities and agencies, provider training, evaluation, support for newborn screening, lead poisoning and injury prevention, and promotion of health and safety in child care settings. Special efforts are made

to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling. Where no services are available, States also use Title V to subsidize or provide categorical direct care.

In FY 2000, HRSA will provide assistance and care for some of the new children and critical new needs identified by CHIP outreach that can not be met by Medicaid or State Child Health plans, such as additional translation, case management, transportation, special public health, disability, and gap filling services effective for low-income children. In addition, HRSA will provide vital population-based public health services and support capacity and resource development needed to ensure adequate health care and improved health status of certain high risk populations.

HRSA – Maternal and Child Health, Healthy Start. HRSA will fund approximately HRSA will fund approximately 13 additional new Healthy Start projects targeting communities with high infant mortality and other socioeconomic risk factors. With these additional projects, HRSA will be funding approximately 95 communities (20 mentoring projects and 75 replication projects) to reduce barriers to care, improve perinatal systems, support private sector partnerships that facilitate welfare to work and community job creation, and reduce racial disparity in health status.

SAMHSA – The Starting Early, Starting Smart in School program provides an opportunity for the integration of behavioral health services into the school setting where the children already receiving these services. To best address the needs of young children and families requires that the services be made available where the clients are most likely to be present, and the services are easily accessed, particularly health clinics and day care and school-based settings. The program is a four-year initiative, designed in three phases. Phase 2, service delivery, began in FY 1998 and continues to FY 2000. The data analysis phase begins in FY 2000. It will include assessments of cohorts of children receiving services under varying settings to determine: 1) the effectiveness of integrating substance-abuse treatment and mental-health services into early childhood settings; 2) if the extension of the integration model will continue to promote and sustain positive child/family outcomes; and 3) the effectiveness of violence intervention activities.

HRSA – Maternal and Child Health, Universal Newborn Hearing Screening and Early Intervention. This program, in partnership with CDC and NIH, will promote universal newborn hearing screening prior to hospital discharge and link the screening to intervention within the community service system, thereby greatly lowering the age at which children with congenital permanent hearing loss are identified, and increasing the ability of these children to perform on school related measures.

HRSA – Maternal and Child Health, Trauma Care/Emergency Medical Services (EMS). HRSA will work with State emergency medical services directors to follow up on the recommendations of the NHTSA report, with particular focus on assessing EMS capacity within their states.

- HRSA – Maternal and Child Health, Emergency Medical Services for Children (EMSC). EMSC is designed to ensure that all children and adolescents, no matter where they live or where they travel, can receive appropriate care in a health emergency. It seeks to improve all aspects of children's acute emergency medical care, including pre-hospital care, emergency department care, hospital care, and rehabilitation, and to prevent such emergencies from occurring. HRSA will increase systems improvement grants to States in order to fund additional evaluation, data improvement, and evidence-based research.

- HCFA – Immunization in children with the complete series of vaccinations in the first two years of life is a widely accepted health care strategy. It is a highly effective intervention to prevent a number of diseases in children and to prevent serious outbreaks of illness. The Medicaid program covers vaccines for children as a basic mandatory covered service. The central importance of childhood immunization is also recognized by the Children's Health Insurance Program (CHIP). Under the legislation, States that create a separate CHIP program must include coverage of the complete series of immunizations. States also are prohibited from imposing co-payments or deductibles on immunization services. Almost all of the CHIP State Plans submitted to HCFA by April 1998 indicated the intention to apply a measure of childhood immunization to their CHIP population as a basic indicator of quality of care.

- Administration Initiative – Promoting Childhood Immunizations. The HHS budget proposes $1.1 billion for childhood immunizations, including the Vaccines for Children program and CDC's discretionary immunization program. The Nation surpassed its childhood vaccination goals for 1997—90 percent or more of America's toddlers received each basic childhood vaccine—as a result of the Administration's initiative. The incidence of vaccine-preventable diseases such as diphtheria, tetanus, measles and polio are at all-time lows. Expanded funding will permit continued high levels of childhood immunization. The FY 2000 budget also includes $83 million to eradicate polio, an increase of $17 million.

- CDC – Immunization. The National Immunization Program (NIP) focuses on several major programmatic areas to achieve its goals, including childhood immunization, adult immunization, and global polio eradication. Although NIP has assistance from many partners, State and local health agencies play a primary role in helping NIP carry out its mission in the United States. State and local health agencies use CDC grant funds for a wide range of activities including hiring staff, conducting surveillance, assessing immunization levels, developing immunization registries, conducting education and outreach, and establishing partnerships with community groups and private sector organizations.

- CDC – Tuberculosis. CDC has developed a national plan to eliminate TB from our country. To achieve this goal, CDC works with local, state, national, and international partners to improve the prevention, diagnosis, and treatment of TB disease. In addition to promoting the more effective use of existing tools for combating TB, CDC is working to develop new diagnostic and treatment tools.

- CDC – Breast and Cervical Cancer Prevention. Through CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP), CDC supports activities at the state and

national level in the areas of screening, referral and follow-up services, quality assurance, public and provider education, surveillance, collaboration, and partnership development. The screening program ensures that eligible women have access to these preventive services, and that state programs: inform all women of the value of early detection, educate physicians about recommended screening guidelines, ensure the quality of mammograms and Pap tests, monitor program effectiveness through appropriate surveillance and evaluation activities, and build effective community-based partnerships for early detection and follow-up.

- CDC – Diabetes and Other Chronic Diseases. In order to prevent or significantly ameliorate the disabling and costly complications of diabetes, CDC's Diabetes Control Programs emphasize ensuring that persons with diabetes have access to quality diabetes care and services. In FY 1999, CDC will provide support to 15 states at the comprehensive level. Comprehensive programs include core program activities and emphasize implementation of public health strategies throughout the entire state, with an expected improvement in access to affordable, high quality diabetes care and services.

- HCFA – Appropriate use of effective medical services is a critical component of HCFA's focus on Medicare beneficiaries. HCFA's efforts to improve medical treatment through its collaboration with Peer Review Organizations is the basis for its performance goals to: 1) increase influenza vaccination, and 2) increase the use of mammograms. PROs, which serve under contract with HCFA, conduct cooperative improvement projects in which they use data to identify opportunities to improve care, and then work to develop interventions that will bring improvement for subject quality indicators. Pertinent to the HCFA performance plan, HCFA and the PROs are working with providers, health plans, and others on influenza vaccination projects, and are networking with local project collaborators to provide education and reminders to improve mammography rates.

- IHS – Restoring Access to Health Care Initiative. In FY 2000, IHS will begin restoring access to basic health services, including assuring that there are adequate facilities and equipment for the provision of health services and providing adequate support services to the tribal health delivery system.

- HRSA – Rural Health Outreach Grants. The Rural Health Outreach and Rural Network Development Grant Programs support the delivery of basic health services to millions of Americans living in underserved rural areas of the country. A wide range of services including primary care, mental health, dental care, health education, specialty care, hospice care are provided through the Outreach Grant Program to small rural communities in almost every state. A few other communities are receiving Network Development Grants to help them develop fully integrated systems of care. These systems usually involve efforts by the local hospital, physicians groups, long-term facilities and even public health agencies to better organize and manage scarce health care resources in rural communities.

- HRSA – Telehealth. HRSA will expand its current rural telehealth activities to include urban telehealth program initiatives. HRSA will provide approximately 10 additional telehealth grants to scientifically evaluate telecommunications as a means for providing telehealth services

in urban communities. In addition, HRSA will also provide more effective distance learning programming to students in isolated training sites, including urban inner-city and rural settings, supervise the training of health professions students in these settings, enhance the development of remote training sites, and expand services into non-traditional health care settings where populations have difficulty obtaining health care (e.g., inner-city housing projects).

HRSA – Health Professions and Nursing Training Programs. These programs address the need to have health professionals in areas where they are most needed, particularly in underserved areas and areas with vulnerable populations. In order to improve the diversity of health professions providers, HRSA programs support training for health career opportunities for minorities and students with disadvantaged backgrounds. Minorities are three times more likely to practice in medically underserved communities than non-minority health professionals. Additional program strategies focus on improving geographic maldistribution in partnership with the States, particularly in community-based training sites.

SAMHSA – The Faculty Development Program (FDP) continues to produce a cadre of physicians and other health professionals who possess the expertise to teach and advocate for substance abuse prevention. This interdisciplinary training program provides the FDP fellows with the unique skills necessary to administer integrated health services. This program, through its penetration into Schools of Medicine, Social Work, Psychiatry, and Public Health, will significantly impact managed health care executives in the future.

AHCPR – To test the effectiveness of health care improvement approaches, AHCPR will: 1) study the implementation of evidence-based information in diverse health care settings to determine effective strategies for enhancing practitioner behavior change and improving patient behavior, knowledge and satisfaction; 2) identify the factors which determine the success of quality improvement strategies and to what extent these vary by the nature of the problem addressed and the target population; 3) test innovative approaches to teaching evidence-based practice to health professionals, including physicians, nurses and dentists; 4) improve the quality of care during transitions between health care settings, including primary care, acute hospital care and long-term care settings, and between specialists to improve integration and to build on the agency's 1997 initiative to study care at the interface of primary and specialty care; and 5) promote the use of shared decision-making in clinical practice and evaluate its impact on quality, costs, and satisfaction.

ASPE – Policy Research. Many states and communities are undertaking or considering significant changes in the delivery of health and human services, including health insurance coverage, performance-based services, comprehensive services for children, assisted living and other services to help adults with disabilities. With the ever increasing changes in the delivery of services, it is critical to assess the impact and measure the effectiveness of these expansions. ASPE supports a number of studies that fill gaps in HHS' ongoing research plan.

OCR – Preventing Discrimination in Access to HHS' Services. Ongoing changes related to increased state flexibility in the organization of health care coverage and services for the poor and disabled receiving Medicaid are likely to continue to expand OCR's responsibilities for

ensuring nondiscrimination in the expenditure of federal funds. OCR will concentrate its resources on the critical civil rights issues surrounding changes in health care coverage and services that are undertaken in the states. To focus its compliance initiatives effectively in an increasingly complex and rapidly changing health care delivery environment, OCR will work with OPDIV partners to improve research and data collection efforts to support targeted enforcement in this changing arena.

The paradox of managed care for vulnerable populations is that, although such arrangements have the potential to improve access for minority and disabled populations, the underlying premise of managed care is control of over-utilization of services. Because managed care may be predicated, in part, on a belief in "excess" care, such systems raise important issues for populations for whom under-service rather than over-utilization has been the historic problem. OCR will focus on assessing the effects of managed care on services to minority and disability communities.

In addition, OCR will continue to work with health care and social services providers, state and local agencies and HHS partners, to ensure that persons of limited English proficiency are not discriminated against on the basis of national origin.

OPHS – The Bilingual/Bicultural Service Demonstration Grant Program will continue to support community-based projects to improve access to health care services for limited-English-proficient (LEP) populations. All projects focus on improving the ability of health care providers and other health care professionals to deliver linguistically and culturally competent health care services to LEP populations.

OPHS – The Office on Women's Health proposes to establish a mechanism by which the National Centers of Excellence in Women's Health can compete for funds to carry out activities in three specific areas, modeled after the Special Interest Projects funded through the CDC Prevention Centers. These three areas are: older women's health, specifically the development of outreach and preventive services to elderly women; the development of cross-disciplinary training programs for health professionals, e.g., nursing and public health with medicine, with a focus on women's health; and the development of programs focused on prevention and clinical services for women at risk of or living with HIV/AIDS.

Selected FY 2000 Performance Goals and Measures

♦ At minimum, achieve the following immunization coverage of at least 90% (baseline 78% in 1996) among children 2 years of age:

- 4 doses of Diphtheria-Tetanus-Pertussis containing vaccine
- 3 doses of Haemophilus influenzae type b vaccine
- 1 dose of Measles-Mumps-Rubella vaccine
- 3 doses of Hepatitis B vaccine
- 3 doses of Polio vaccine *CDC Plan*

- Increase the percentage of Medicaid two-year old children who are fully immunized. FY 2000 measure: Group 1 States (early voluntary setting of baselines and goals) to measure State-specific numerical targets for immunizations for children under two years of age in State Medicaid programs. Group 2 States (all others) will set baselines for Medicaid. [Developmental] *HCFA Plan*

- Increase the percentage of Medicare beneficiaries age 65 years and older who receive an influenza vaccination. FY 2000 measure: HCFA has adopted the Healthy People 2000 goal of achieving at least a 60 percent influenza immunization rate among non-institutionalized, high-risk populations, including Medicare beneficiaries age 65 and older. *HCFA Plan*

- Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children in order to help implement the State Child Health Insurance Program, from a baseline of 8.45 million served to 9.025 million persons served in FY 2000. *HRSA Plan*

- Continue to assure access to preventive and primary care for minority individuals. Target for FY 1999 and FY 2000: 65 percent of patients will be racial minorities or of Hispanic origin. Baseline: In FY 1997 the population served included 26 percent African American, 31 percent Hispanic, 8 percent Asian/other. *HRSA Plan*

- At least 85% of tuberculosis patients will complete a course of curative tuberculosis treatment within 12 months of initiation of treatment (some patients require more than 12 months treatment). *CDC Plan*

- At least 75% of contacts of infectious tuberculosis cases and 70% of other high risk infected persons will be placed on preventive therapy and will complete a full treatment regimen. *CDC Plan*

- At least 67% of women in the NBCCEDP aged 50 and older with breast cancer will be diagnosed at localized stage or stage 0/1. *CDC Plan*

- The rate of invasive cervical cancer diagnosed in women aged 50 and older screened by the NBCCEDP is no more than 40 per 100,000 Pap tests provided. *CDC Plan*

- For all states that receive CDC funding for comprehensive diabetes control programs, increase by 10% the percentage of diabetics who receive an annual eye exam and annual foot exam. *CDC Plan*

- Continue to assure access to preventive and primary care for low income individuals. Target for FY 1999 and FY 2000: 86 percent of patients will be at or below 200 percent of the Federal poverty level. Baseline: 86 percent of patients were at or below 200 percent of the Federal poverty level in FY 1997. *HRSA Plan*

- Develop and operate collaborative models of health services in rural areas which will serve about 720,000 persons. Baseline: 616,000 (1998). *HRSA Plan*

- Increase the number of children served by Title V from 12 million (est.) in 1997. [Developmental] *HRSA Plan*

- During FY 2000, assure that at least 24% of the AI/AN population obtain access to dental services. *IHS Plan*

- In order to increase access for minorities and persons with disabilities to nondiscriminatory services in managed care plan settings, OCR will increase the number of managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act. FY 2000 measure: 44 corrective actions and no violation findings. Baseline: 10 corrective actions and no violation findings FY 1998. *OCR Plan*

- In order to increase access to HHS services for limited-English proficient (LEP) persons, OCR will increase the number of HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. FY 2000 measure: 140 corrective actions and no violation findings. Baseline: 98 corrective actions and no violation finding FY 1998. *OCR Plan*

Programs Supporting This Objective

AHCPR
Research on Health Costs, Quality, and Outcomes
ASPE
Policy Research
CDC
Immunization
Tuberculosis
Breast and Cervical Cancer Prevention
Diabetes and Other Chronic Diseases
HCFA
Medicare
Medicaid
Children's Health Insurance Program
Health Professions and Nursing Training Programs

HRSA
Primary Care
  Health Centers
  National Health Service Corps
Maternal and Child Health
  Maternal and Child Health Block Grant
  Healthy Start Initiative
  Universal Newborn Hearing Screening and Early Intervention
  Emergency Medical Services for Children
  Traumatic Brain Injury Program
  Trauma Care/Emergency Medical Services
Rural Health
  Rural Health Outreach Grants
  Rural Health Policy Development
  Telehealth
Workforce Information and Analysis
Health Education and Assistance Loans
IHS
Treatment
  Hospitals & Health Clinics
  Dental Services
  Mental Health
  Alcohol & Substance Abuse
  Contract Health Services
  Urban Health
  Indian Health Professions
Prevention

Public Health Nursing
Health Education
Community Health Representatives
Environmental Health Support
Capital Programming/Infrastructure
Health Care Facilities Construction
OCR
Preventing Discrimination in Access to HHS' Services
OPHS
Office of Minority Health
Office of Women's Health
SAMHSA
Knowledge Development and Application
Children's Mental Health Services
Protection and Advocacy
Substance Abuse Block Grant
Mental Health Performance Partnership Block Grant

HHS 3.3: Improve Access to and the Effectiveness of Health Care Services for Persons with Specific Needs

From the HHS Strategic Plan, September 1997. The Department administers federal grants to states and local agencies to provide high-quality prevention and clinical services for individuals whose access is limited to publicly funded programs. For these individuals, the Department helps states to provide substance abuse prevention and treatment services, mental health services, maternal and child health services (including services for children with special health needs), and HIV/AIDS services. In addition, HCFA supports payment for many of these services through the Medicare and Medicaid programs.

The need for these services is growing. For example, of the 33 million children and adolescents between the ages of 9 and 17 in the United States, 3.5 million to 4 million have a serious emotional disturbance: many will require help from HHS-funded programs. Approximately 9 percent of the adolescents in the 1996 National Household Survey had used illicit drugs in the last month. Again, many will seek treatment in HHS-funded programs. Strategies for preventing substance abuse have been discussed under Goal 1. However, improvements in the capacity and effectiveness of substance abuse and mental health programs are of equal concern. A 1994 survey found that nearly half of those needing treatment did not receive it.

While most American children require few medical services, a significant percentage have special health care needs. Depending on the definition used, an estimated 16 to 31 percent of U.S. children have a chronic physical, developmental, behavioral, or emotional condition and require health or related services beyond those children typically need. These children and their families face fragmentation in the health care system and a lack of organized systems of care. They also face difficulties in obtaining insurance coverage. It is essential that access for these children be monitored and that persistent gaps be closed.

Recent advances in treatment promise major improvements in the longevity and quality of life for people with HIV disease. At the same time, the epidemic is increasingly concentrated in minority and disadvantaged populations, those with the narrowest access to care. Progress in dealing with this epidemic will require new and more effective programs to support patients in primary care and in helping them adhere to complex medical care and drug therapies. The annual cost per patient of combination anti-retroviral drug therapy, including protease inhibitors, is estimated at $10,000 to $12,000. At least 30 percent of those with HIV are uninsured, so that government efforts to widen access to these new therapies are essential.

Key FY 2000 Activities, Initiatives, and Strategies

- Administration Initiative – Ensuring Access to AIDS therapies (Ryan White). The FY 2000 budget proposes an increase of $99 million in Ryan White treatment activities. In total, the FY 2000 budget proposes $1.5 billion in Federal spending for activities authorized by the Ryan White/CARE Act. This represents a 7 percent increase over FY 1999 levels.

HRSA – HIV/AIDS. *HIV Care*. Funds are used to support a wide range of services: home and community-based health care and support services; continuation of health insurance coverage, through a Health Insurance Continuation Program (HICP); pharmaceutical treatments, through the ADAP Program; HIV care consortia that assess needs, organize and deliver HIV services in consultation with service providers, and contract for services; and direct health and support services.

HIV Emergency Relief Grants. These grants are used for community-based outpatient health and support services for low-income persons living with AIDS/HIV, including comprehensive medical care, prescription drugs, counseling, transportation, meals-on-wheels programs, home care and hospice care. Funds may also be used to provide in-patient case management for AIDS/HIV patients to prevent unnecessary hospitalization or to expedite hospital discharge.

HIV Early Intervention Services. This program supports outpatient HIV early intervention services, specifically targeting previously underserved populations, which have had limited access to care, including women, children, adolescents, people of color, and substance abusers. In FY 2000, HRSA plans to fund new sites, all of which are communities of significant need for Federal support.

HIV Pediatric Grants. This program focuses on increasing the access of HIV/AIDS-affected women, infants, children, and youth to a comprehensive, community-based, family-centered system of care. The focus of the program has further expanded to develop innovative models that link systems of comprehensive community-based medical and social services for the affected population with the National Institutes of Health and other clinical research trials. Funds support innovative strategies and models to organize, arrange for, and deliver comprehensive services through integration into ongoing systems of care.
Dental Services Program. Through grants, this program reimburses accredited dental schools and other post-doctoral dental education programs for the documented uncompensated costs they have incurred for providing oral health treatment to HIV infected patients.

OPHS – The Office of HIV/AIDS Policy (OHAP) manages the overall HIV/AIDS activities throughout the Department. OHAP's coordination efforts integrate the Department's policies, programs and activities designed to prevent the occurrence of HIV infection and AIDS and promote effective mechanisms to serve those infected with HIV. This includes analyzing and contributing to the design of the Department's priorities to ensure a comprehensive national response to the HIV/AIDS epidemic. OHAP also provides advice and guidance to the Assistant Secretary for Health and Surgeon General (ASH/SG), the Deputy Secretary and Secretary of the Department on HIV/AIDS programs and policies.

Activities and responsibilities of the office that are expected in FY 2000 include the management of the Department's 25 member HHS Coordinating Group on HIV/AIDS which serves as the forum for providing advice and guidance to OPDIVs, STAFFDIVs and the Secretary on critical issues concerning HIV/AIDS policy and the Secretary's Advisory Committee on Blood Safety and Availability and the ASH/SG's Blood Safety Committee

involving a range of Department-wide initiatives and activities within the purview of these committees.

- Administration Initiative – Providing Critical Mental Health Prevention and Treatment Services. The FY 2000 President's Budget provides a $70 million, or 24 percent, increase for the Mental Health Block Grant, which provides integral support to States for services to people with mental illness. In addition to increasing funding for this vulnerable population, our budget requests a $5 million, or 19 percent, increase for the Projects for Assistance in Transition from Homelessness (PATH) program. This program provides supportive services to homeless persons with a mental illness.

- SAMHSA – The Comprehensive Community Mental Health Services for Children and their Families Program seeks to provide intensive community-based services for children with serious emotional disturbances and their families. The program features a broad array of services tailored to meet the needs of the child through an individualized service planning process. In FY 2000, HHS will continue to support and evaluate approximately 50 grants, allowing continued national progress in improving outcomes for a larger number of children with serious emotional disturbances and their families.

- HRSA – Maternal and Child Health Block Grant. In FY 2000, HRSA will provide additional funds to States to provide services for the approximately 12 million children who are presently in critical need of multi-disciplinary services and do not have adequate insurance to meet the special needs necessary to develop, function and learn, including optional benefits not provided by some state CHIP plans and urgent treatment and preventive services for children who will continue to be uninsured and under-insured. This program also supports the development of coordinated care delivery systems and services for children with special health care needs.

- SAMHSA – A major objective of the National Drug Control Strategy is to close the treatment gap for substance-abuse victims and reduce drug use by 50 percent in the next ten years. To improve program impacts for this special needs population in FY 2000, SAMHSA will increase efforts in two programs that focus on reducing the treatment gap: 1) the Substance Abuse Prevention and Treatment Block Grant, which will provide for nationwide expansion of treatment services and aid in the reduction of treatment waiting lists; and, 2) the Targeted Capacity Expansion Program, which will provide rapid and strategic responses to the demand for alcohol and drug abuse treatment services that are regional or local in nature.

- ACF – Developmental Disabilities (DD). In order to improve the health of people with developmental disabilities and increase their access to needed health care services, DD works to ensure that individuals with developmental disabilities and their families have access to the health care information they need to make choices; that health care is available, affordable, accessible, and equitable; and that health care personnel are appropriately qualified to meet the health care needs of people with developmental disabilities.

- OPHS/HRSA – The National Hispanic Prenatal Hotline Project funded under the National Coalition of Hispanic Health and Human Services Organizations cooperative agreement

establishes a national hotline to provide individualized, culturally/linguistically appropriate information regarding prenatal care to Hispanic consumers in the United States and Puerto Rico. Through a newly established database, individuals can access culturally written information on prenatal care and health care providers are able to access information on how to provide culturally and linguistically appropriate prenatal care services.

- FDA – Drugs. FDA's Orphan Products Grant Program encourages clinical development of products used to treat rare diseases or conditions. A product used to treat a disease or condition that affects fewer than 200,000 persons in the United States is called an Orphan product. Companies are often reluctant to invest time and money to develop orphan products because the market is so small. To encourage research and product development for rare diseases and conditions, FDA offers grants, special privileges and marketing incentives to companies under the Orphan Drug Act. Orphan products (drugs, biologics, medical devices, medical foods) are needed to help reduce pain and suffering for persons with diseases such as hemophilia, multiple sclerosis, cystic fibrosis, rare cancers, and as many as 5,000 other known rare disorders that affect as many as 20 million Americans.

- FDA – Drugs. FDA is dedicated to combating AIDS and other life threatening conditions by streamlining the development and approval process for new therapies. FDA's broad-based, multi-disciplinary research programs have played a significant role in the development of vaccines, therapeutic agents, and test kits for possible use in AIDS and AID-related conditions by defining parameters that must be met regardless of sponsor. FDA continues to enlarge the scope of its AIDS-related activities as new data on HIV, AIDS, and AIDS-related diseases become available and as clinical trials of new therapies, vaccines, and diagnostic tests expand.

- FDA – Drugs. FDA is encouraging patients to play an integral part in the decision making process for healthcare. FDA appoints patient representatives to participate on Advisory Committees that consider new drugs for approval. FDA also plans to establish a public registry containing information about clinical trials for experimental drugs and biologics that will be used to treat serious or life threatening diseases and conditions. This registry will provide consumers greater access to information about clinical trials and increase their opportunity to participate in these trials.

- HRSA – Organ Procurement and Transplantation. HHS issued regulations in 1998 to provide greater equity in the organ transplantation system. Physicians and health care personnel, as well as the general public, require education to recover all organs lost because donation is not considered. In FY 2000, HRSA plans to sustain and increase its efforts with a variety of additional partners to increase organ donation and provide for increased production and distribution of educational materials. HRSA will also support efforts directed at a better understanding of the consent and referral processes that take place between hospital and referral personnel and families.

- HRSA – National Bone Marrow Donor Program. This program maintains a program of grants and/or contracts to qualified recipients to advance the knowledge of bone marrow transplantation and to increase bone marrow donor recruitment among targeted populations.

The program initiates and manages studies which address problems relating to bone marrow donation and the matching of patients with donors. They monitor trends and analyze data on the efficiency and effectiveness of bone marrow procurement, the allocation of bone marrow among transplant centers and transplant patients and on other aspects of bone marrow transplantation. The program is responsible for policy and regulatory development in the area of bone marrow recruitment, and matching. FY 2000 efforts will focus on continued support for the National Registry and an ongoing evaluation of the scientific and clinical status of marrow transplantation.

- AHCPR – Improving outcomes for the chronically ill and elderly. Two thirds of American will dies from chronic, disabling conditions, yet current research does not begin to provide solutions to this challenge. AHCPR will examine how various clinical and system characteristics affect the health outcomes, quality access, and satisfaction, for the elderly and chronically ill. A particular area of inquiry will be improving diagnostic accuracy. This will include a specific focus on the health outcomes and needs of vulnerable elderly Medicare beneficiaries; racial and ethnic minorities, who represent a large and growing proportion of this population; women; and those with functional impairments.

- AHCPR – Outcomes and effectiveness of health care for children. AHCPR will conduct large, multi-site effectiveness and/or cost-effectiveness studies of diagnostic, prevention, treatment rehabilitative, or palliative interventions for children and adolescents with severe chronic illnesses and disabilities (e.g.: asthma, diabetes, juvenile rheumatoid arthritis, cancer, depression, and chronic and severe physical impairments).

- AHCPR – Centers of excellence in women's health research. These AHCPR projects will conduct research on the impact of new models of care on quality, cost, and effectiveness. Where applicable, these centers will be coordinated with those funded by the Office of Women's Health.

- NIH – The NIH devotes a considerable portion of its resources to illuminating the cause, effects, diagnosis, prevention and treatment of serious medical conditions which disproportionately affect Americans from different cultural, ethnic, and linguistic groups. Among the numerous activities ongoing, the National Cancer Institute's Colorectal, and Ovarian Cancer Screening trial is a randomized study to determine whether certain screening tests will reduce the number of deaths which significantly affect minorities and the elderly. The National Institute of Diabetes and Digestive and Kidney Diseases encourages increased biomedical and biobehavioral research efforts on the disproportionate impact of diabetes in minority populations – including African Americans, Hispanic Americans, Asian Americans and Pacific Islanders, Alaska Natives, and Native Americans and Hawaiians. The National Heart, Lung, and Blood Institute supports numerous programs designed to enhance the availability of information on cardiovascular health for the diverse ethnic, cultural, and linguistic groups within the U.S. population.

- OPHS – A comprehensive Surgeon General's report on mental health (the first ever on this area of health care) scheduled for release in FY 2000 will include cutting edge information

about the status of mental health research and services within the United States. The report is expected to serve as a basis for shaping the Federal government's future mental health program initiatives, as well as providing the public with valuable information about mental health issues impacting the country. As mental health and mental illness become more main stream and less stigmatized, health insurance coverage is likely to become less restrictive.

OPHS – The Center for Linguistic and Cultural Competence in Health Care develops and evaluates models, conducts research, and provides technical assistance to providers to address the cultural and linguistic barriers to health care delivery and increase limited English speaking individuals' access to health care. FY 2000 activities include: disseminating information on current language and cultural competency model programs, techniques, organizational and governmental policies; launching a culturally competence systems change initiative; conducting an evaluation of selected sites to determine the effectiveness of culturally competent programs on ethnically diverse patients; commissioning papers on development of culturally competent training programs for health care providers; developing a research project on cultural competence health delivery programs, and initiating research on impact of culturally competent services on patient treatment protocols and outcomes. All products will be disseminated through the Office of Minority Health Resource Center (OMHRC) and through the OMHRC web-site.

OCR – Preventing Discrimination in Access to HHS' Services. The paradox of managed care for vulnerable populations is that, although such arrangements have the potential to improve access for minority and disabled populations, the underlying premise of managed care is control of over-utilization of services. Because managed care may be predicated, in part, on a belief in "excess" care, such systems raise important issues for populations for whom under-service rather than over-utilization has been the historic problem. OCR needs to be able to assess the effects of managed care on services to minority and disability communities.

Selected FY 2000 Performance Goals and Measures

♦ Increase the percent of children with special health care needs with a medical/health home. [Developmental] *HRSA Plan*

♦ Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health) for persons with HIV to a level that takes account of new clients in the program.

- *HIV Emergency Relief Grants*. FY 2000 Goal, 2.97 million total visits. Baseline: 2.67 million visits in 1996.

- *HIV Care Grants to States*. FY 2000 Goal, 1.23 million total visits. Baseline: 1.13 million visits in 1996. *HRSA Plan*

♦ Increase the number of AIDS Drug Assistance Programs (ADAP) clients receiving appropriate antiretroviral therapy (consistent with clinical guidelines) through State ADAPs during at least

one month of the year, to a projected monthly average of 82,200 by the year 2000. Baseline: 55,000 in 1998. *HRSA Plan*

- Increase by 20% over two years the number of organ donors nationally from the effective date of the final HCFA Rule on Conditions of Participation of Hospitals to 6,588 organ donors in FY 2000. *HRSA Plan*

- Increase by 10% the number of unrelated bone marrow donors over previous year totals to 3.12 million bone marrow donors in FY 2000. *HRSA Plan*

- Increase the number of health care providers trained to meet the health needs of people with developmental disabilities as a result of DD program intervention. FY 1997 baseline = 2,922 health care providers. [Developmental] *ACF Plan*

- In order to increase access for minorities and persons with disabilities to nondiscriminatory services in managed care plan settings, OCR will increase the number of managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act. FY 2000 measure: 44 corrective actions and no violation findings. Baseline: 10 corrective actions and no violation findings FY 1998. *OCR Plan*

- Increase the proportion of people with major depressive disorders who obtain treatment to 54% in FY 2000. Baseline: 34% (1992) *OPHS Plan*

- Decrease the annual rate of suicide to 10.5 (per 100,000 population) in FY 2000. Baseline: 11.2 (per 100,000 population in 1995) *OPHS Plan*

Programs Supporting This Objective

ACF
Developmental Disabilities
AHCPR
Research on Health Costs, Quality, and Outcomes
FDA
Drugs
HRSA
Primary Care
  National Hansen's Disease Program
  Black Lung Clinics
HIV/AIDS
  HIV Care
  HIV Emergency Relief Grants
  HIV Early Intervention Services
  HIV Pediatric Grants
  Education and Training Centers
  Dental Services Program
Maternal and Child Health
  Maternal and Child Health Block Grant
  Universal Newborn Hearing Screening and Early Intervention
  Healthy Start Initiative
  Emergency Medical Services for Children
HRSA (continued)
  Traumatic Brain Injury Program
  Trauma Care/Emergency Medical Services
Health Professions and Nursing Training Programs
National Bone Marrow Donor Program
Organ Procurement and Transplantation
NIH
Research Program
OCR

Preventing Discrimination in Access to HHS' Services
OPHS
Office of HIV/AIDS Policy
Office of the Surgeon General
SAMHSA
Targeted Capacity Expansion
Children's Mental Health Services
Protection and Advocacy
Substance Abuse Block Grant
Mental Health Performance Partnership Block Grant

HHS 3.4: Protect and Improve Beneficiary Health and Satisfaction with Medicare and Medicaid

From the HHS Strategic Plan, September 1997. Medicare and Medicaid are the nation's largest purchasers of health services, providing insurance coverage for approximately 72 million elderly, disabled, and economically disadvantaged Americans. Over the last thirty years, Medicare has significantly contributed to life expectancy, to the quality of life, and to protection from poverty for the aged and disabled. Medicaid has improved birth outcomes, childhood immunization rates, and access to preventive services, resulting in overall improvements in the health of America's children. Medicaid also pays more than 50 percent of nursing home costs.

The major structural changes taking place in the nation's health system, and in the management of the Medicaid program as states assume increasing responsibility for program design and policy, offer both risks and opportunities to beneficiaries of both of these programs. For example, incentives for Medicare beneficiaries to join managed care plans have become stronger as a result of provisions in the Balanced Budget Act, creating a wider range of choices for beneficiaries. In many states, managed care is already the sole or dominant system for Medicaid beneficiaries. As these transformations unfold, the Department, through HCFA, will give priority to ensuring that the quality of services provided to beneficiaries and their satisfaction with those services are not compromised.

Key FY 2000 Activities, Initiatives, and Strategies

- HCFA – The primary intervention designed to improve beneficiary satisfaction with the health care services they receive is the National Medicare Education Program (NMEP). The NMEP will provide beneficiaries with accurate, easily understandable information about their health insurance options to assist them in becoming more active participants in their health care decisions. This includes providing comparative information on benefit structures, cost-sharing requirements, and quality and performance indicators. The information is intended to help beneficiaries choose whether they want to be in fee-for-service or managed care; and if they choose managed care, which health plan would be best for them. The NMEP will also provide data when available on other Medicare+Choice options, such as medical savings accounts and private fee-for-service plans.

- HCFA – Central to performance measurement for HCFA is the beneficiary focus that pervades its goals and objectives. A critical component of that focus is the effectiveness of medical treatment that is provided to Medicare beneficiaries. HCFA's efforts to improve medical treatment through its collaboration with Peer Review Organizations is the basis for its performance goals to: 1) improve heart attack survival rates, 2) increase influenza vaccination, and 3) increase the use of mammograms. PROs, which serve under contract with HCFA, conduct cooperative improvement projects in which they use data to identify opportunities to improve care, and then work to develop interventions that will bring improvement for subject quality indicators. Pertinent to the HCFA performance plan, HCFA and the PROs are

fostering utilization of interventions to treat heart attacks and improve survival rates; are working with providers, health plans and others on influenza vaccination projects; and are networking with local project collaborators to provide education and reminders to improve mammography rates.

Administration Initiative – Promoting Childhood Immunizations. The HHS budget proposes $1.1 billion for childhood immunizations, including the Vaccines for Children program and CDC's discretionary immunization program. The Nation surpassed its childhood vaccination goals for 1997—90 percent or more of America's toddlers received each basic childhood vaccine—as a result of the Administration's initiative. The incidence of vaccine-preventable diseases such as diphtheria, tetanus, measles and polio are at all-time lows. Expanded funding will permit continued high levels of childhood immunization. The FY 2000 budget also includes $83 million to eradicate polio, an increase of $17 million.

HCFA – The importance of childhood immunization is demonstrated in the Children's Health Insurance Program (CHIP). Under the legislation, States that create a separate CHIP program must include coverage of the complete series of immunizations. States also are prohibited from imposing co-payments or deductibles on immunization services. Almost all of the CHIP State Plans submitted to HCFA by April 1998 indicated the intention to apply a measure of childhood immunization to their CHIP population as a basic indicator of quality of care.

Moreover, highly effective, evidence-based interventions are available to raise childhood immunization coverage levels. A large number of studies have shown that performance measurement through HEDIS®, registries, or other assessment techniques and the use of recall and reminder systems to identify and track children in need of vaccination will substantially raise coverage levels. A major barrier to childhood immunization is the information gap that exists among parents and providers about the immunization status. Research indicates that over three-fourths of parents of children in need of immunization believe their child is completely vaccinated. Similarly, providers also tend to greatly over-estimate the immunization coverage levels of their patients. This information gap is an important reason why both performance measurement and recall and reminder systems are highly effective, evidence-based intervention strategies that are recommended by both the Centers for Disease Control and the Advisory Committee on Immunization Practices.

HCFA – The President and the Secretary of HHS have announced an initiative to toughen nursing home enforcement tools and strengthen Federal oversight of nursing home quality and safety standards. Key components of FY 2000 activities proposed by HCFA toward achieving the President's objectives include increased direct survey activities and emphasis on nursing home effectiveness in preventing bed sores, dehydration, and malnutrition, accompanied by increased sanctions for violations; increased support contract activities, including review of nursing homes' systems to prevent, identify, and stop physical or verbal abuse, neglect, and misappropriation of resident property; and increased Federal oversight, including that required by the toughening of the definition of poor performing facility.

AHCPR – AHCPR's priority for new research is more focused than past efforts to respond directly to the priority needs of Medicare and Medicaid. Change and growth in the Medicare and Medicaid populations will continue to affect health care cost, which, in turn, raises concerns about the assurance of health care quality. Examples of AHCPR activities supporting Medicare and Medicaid beneficiaries include: 1) research on conditions that are common, costly, and for which there is substantial variation in practice, conditions that represent major Medicare expenditures; 2) providing objective, science-based, timely information to health care decision makers-- patients and clinicians, health system leaders, and policy makers; 3) health care cost and utilization surveys, such as CAHPS and MEPS, that provide information supporting health plan choices and coverage decisions; and 4) tracking the national impact of the Children's Health Insurance Program on access and cost of care for children.

OCR – Preventing Discrimination in Access to HHS' Services. Ongoing changes related to increased state flexibility in the organization of health care coverage and services for the poor and disabled receiving Medicaid are likely to continue to expand OCR's responsibilities for ensuring nondiscrimination in the expenditure of federal funds. OCR will concentrate its resources on the critical civil rights issues surrounding changes in health care coverage and services that are undertaken in the states. To focus its compliance initiatives effectively in an increasingly complex and rapidly changing health care delivery environment, OCR will work with OPDIV partners to improve research and data collection efforts to support targeted enforcement in this changing arena.

  The paradox of managed care for vulnerable populations is that, although such arrangements have the potential to improve access for minority and disabled populations, the underlying premise of managed care is control of over-utilization of services. Because managed care may be predicated, in part, on a belief in "excess" care, such systems raise important issues for populations for whom under-service rather than over-utilization has been the historic problem. OCR will focus on assessing the effects of managed care on services to minority and disability communities.

  In addition, OCR will continue to work with health care and social services providers, state and local agencies and HHS partners, to ensure that persons of limited English proficiency are not discriminated against on the basis of national origin.

Selected FY 2000 Performance Goals and Measures

♦ Improve satisfaction of Medicare beneficiaries with the health care services they receive. FY 2000 measures:

  Managed care. Increase the percentage of health plans where more than a specified percent of beneficiaries report satisfaction with getting needed care, getting care without long waits, the quality of communication with the physician, and the administrative aspects of obtaining care. [Developmental]

Fee-for-Service. Complete design and pre-implementation activities necessary to carry out a fee-for-service data collection and reporting initiative, to begin in FY 2001. [Developmental] *HCFA Plan*

- Increase the percentage of Medicaid two-year old children who are fully immunized. FY 2000 measure: An initial group of States will measure their immunization rates at the end of FY 2000 using the same methodology they used for their baseline in FY 1999; State-specific numerical targets for immunizations will be established as percentage increases over established baselines, in immunized children 2 years old enrolled in State Medicaid programs. The process will be repeated in a staggered manner for a second and third wave of States beginning in FY 2000 and FY 2001. [Developmental] *HCFA Plan*

- Decrease the 1-year mortality rate among Medicare beneficiaries hospitalized for heart attacks from 31.4% in 1995 to 27.4% in 2000. *HCFA Plan*

- Increase the percentage of Medicare beneficiaries age 65 years and older who receive an influenza vaccination. FY 2000 measure: HCFA has adopted the Healthy People 2000 goal of achieving at least a 60 percent influenza immunization rate among non-institutionalized, high-risk populations, including Medicare beneficiaries age 65 and older. *HCFA Plan*

- Increase the percentage of Medicare beneficiaries age 65 years and older receiving a mammogram. FY 2000 measure: Consistent with the Healthy People 2000 goal, HCFA's goals is that 60 percent of Medicare beneficiaries age 65 and older will receive a mammogram in a two-year period. *HCFA Plan*

- Decrease the prevalence of pressure ulcers in long-term care facilities. The development of pressure ulcers is an undesirable outcome that can be prevented in most residents. FY 2000 goal: To establish the baseline, targets, and interventions to accelerate the reduction of the incidence and prevalence of pressure ulcers in long-term care facilities. Baseline: Target date of September 2000 for establishing a baseline. [Developmental] *HCFA Plan*

- Decrease the prevalence of restraints in long-term care facilities. In FY 2000, the prevalence of the use of physical restraints in long-term care facilities will be reduced to 13 percent. *HCFA Plan*

- In order to increase access for minorities and persons with disabilities to nondiscriminatory services in managed care plan settings, OCR will increase the number of managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act. FY 2000 measure: 44 corrective actions and no violation findings. Baseline: 10 corrective actions and no violation findings FY 1998. *OCR Plan*

- In order to increase access to HHS services for limited-English proficient (LEP) persons, OCR will increase the number of HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. FY 2000 measure: 140 corrective actions and no violation findings. Baseline: 98 corrective actions and no violation finding FY 1998. *OCR Plan*

Programs Supporting This Objective

AHCPR
Medical Expenditure Panel Surveys
Research on Health Costs, Quality, and Outcomes
HCFA
Medicare
Medicaid
Medicare+Choice
Peer Review Organizations
OCR
Preventing Discrimination in Access to HHS' Services

HHS 3.5: Enhance the Fiscal Integrity of HCFA Programs and Ensure the Best Value Health Care for Beneficiaries

From the HHS Strategic Plan, September 1997. The Health Care Financing Administration (HCFA) is the world's largest health insurance entity, processing more than 800 million claims per year, and approximately $1.8 billion in plan payments each month to managed care organizations. Despite the enormous growth in size and complexity the program has experienced, the structure and operations of Medicare have remained substantially unchanged over the last thirty years. Over the next several years, HCFA will undertake a major modernization of the program, preparing to meet the challenges of the coming decade. The demographic changes already noted have enormous implications for Medicare and Medicaid. With a drop in the ratio of active workers to retirees, scheduled Medicare payroll tax revenues will not keep pace with program expenditure levels. The large expected growth in the number of the very old—those over age 85—will significantly increase demands for long-term care under Medicaid.

Medicare and Medicaid together account for nearly one-third of health spending in the United States. Programs of this size and complexity demand prevention of improper, abusive or fraudulent claims straining the fiscal resources of the system. Certain program areas seem to be prone to fraud and abuse. For example, there have been many accounts of unnecessary home health services being provided to beneficiaries, excessive payments being made to suppliers for durable medical equipment, as well as providers fraudulently billing for services not rendered or exaggerating the level of services provided to obtain a higher level of reimbursement.

Prevention is the best remedy. This starts with paying appropriate claims correctly the first time. To do this we rely on the States and Medicare contractors' pre-payment and post-payment medical review, fraud and abuse detection, overpayment collections and provider audit efforts.

Key FY 2000 Activities, Initiatives, and Strategies

- Administration Initiative – Reforming HCFA Management. HCFA administers Medicare, Medicaid, and CHIP, and oversees State health insurance regulation of individual and small group markets. The agency faces the important challenge of modernizing its administrative infrastructure – coordinating the work of dozens of contractors as well as State and territorial governments – while providing superior customer service to almost 70 million beneficiaries. HCFA is further reforming its operations in order to adapt to the changing health care market and increase its accountability as a prudent purchaser of health care.

- Administration Initiative – Combating Medicare and Medicaid Fraud, Abuse, and Waste. As a result of the Administration's overall efforts as well as prior year judgments, settlements, and administrative impositions, the Federal government in 1998 collected $296 million in cases resulting from health care fraud and abuse, of which $271 million was returned to the Medicare Trust Fund, and $9 million was recovered as the Federal share of Medicaid. HCFA's main

focus on preventing and detecting fraud and abuse is through the Medicare Integrity Program (MIP) and the Health Care Fraud and Abuse Control (HCFAC) account.

Under the Health Insurance Portability and Accountability Act of 1996, funding to combat health care fraud, waste, and abuse increases in FY 2000 for both MIP and HCFAC. MIP increases $70 million in FY 2000 while HCFAC increases $20 million. These additional funds will help further the Department's efforts, with the assistance of the Department of Justice, to protect the integrity of the Medicare trust funds and the General Fund.

The FY 2000 budget also includes new proposals to combat Medicare fraud, waste, and abuse. These include eliminating excessive overpayments for the drug Epogen and mark-ups for other outpatient drugs, requiring private insurance companies to provide secondary payer information so that Medicare does not pay for services that should be paid by another insurer, reducing the misuse of partial hospitalization services, and expanding the use of "Centers of Excellence" as a permanent part of Medicare. These proposals are expected to save the Medicare trust funds $240 million in FY 2000 and $2.9 billion over five years.

The HHS budget also works to reduce Medicaid fraud. First, States would be allowed to suspend or restrict eligibility for beneficiaries who have been convicted of certain crimes in State courts. The second proposal would prevent debarred individuals from continuing to bill Medicaid by affiliating themselves with other providers. This provision closes the loophole by prohibiting providers and provider organizations in good standing from hiring or establishing affiliations with debarred individuals.

- AoA – Operation Restore Trust. AoA cooperated with the Office of Inspector General to develop performance measures for the Health Care Anti-Fraud, Waste and Abuse Community Volunteer Demonstration program. Measures include, for example, tracking the number of health care anti-fraud cases opened as a result of each local project's activities and the amount of money recouped by the projects. Such measures are essential as the community demonstration program expands nationwide.

- HCFA – Medicare's primary mission is to pay for beneficiaries' health care. It is essential that the Medicare claims payment systems and other mission critical systems continue to operate past the millennium so that beneficiaries continue to receive needed health care. All computer hardware, software, data exchanges, and telecommunications are potentially at risk from the millennium date change. Therefore, HCFA will ensure that all aspects of claims processing operation and other mission-critical operations are tested for millennium compliance. HCFA will supervise the analysis, renovation, testing, and certification of internal HCFA systems and the systems of the Medicare contractors and the standard system maintainers in order to meet this goal

- HCFA – The provider audit process is HCFA's primary instrument to safeguard payments made to institutional providers, which are paid on an interim basis and whose costs are finally settled through the submission of an annual Medicare cost report. The aspiration for current and future years is to perform audits in an effective manner with an emphasis on auditing those

providers where program dollars are most at risk. HCFA thereby seeks to recover increased program dollars through a more heavily focused audit effort on those areas of the providers' cost reports that lend themselves to more abusive situations.

- HCFA – HCFA continues to carry out a corrective action plan specifically designed to reduce payment errors made under the Medicare fee-for-service program. The corrective action plan focuses planned medical review and other activities on targeted high-risk areas, such as physician office visits, physician evaluation and management, medical documentation, home health services, durable medical equipment, hospital outpatient services, and laboratory services. HCFA is developing the capacity to project precise error rates which are valid below the national level, to improve their ability to target problem areas, and better manage Medicare contractor performance and the Medicare program as a whole.

- HCFA – In FY 2000, HCFA will request that the OIG repeat its evaluation of improper payments for home health services for a third and final time to determine if HCFA's activities have reduced the rate of improper payment. HCFA is continuing interventions, including: regulations for re-enrollment for home health agencies; a doubling of home health cost report audits under the Medicare Integrity Program; implementing provisions authorized by the Balanced Budget Act such as barring felons from participating in Medicare and collecting information to assess the financial stability of home health agencies; continuing Operation Restore Trust's coordinated approach to program integrity and funding State survey agencies to integrate coverage and quality reviews of home health agencies; and working closely with the home health industry to provide education to ensure that home health agencies and the physicians who certify home health services for their patients are aware of home health overpayment problems and support HCFA in preventing fraud and abuse.

- HCFA – In addition to increasing the volume of medical reviews, HCFA is developing methods to improve the efficiency of medical reviews. Selected actions include the following. 1) HCFA will work with Contractor Medical Directors to create more local medical review policy. Local medical review policies serve as the basis for medical necessity decisions and are critical to assessing the reasonableness of a claim. 2) Acceptance of local policies by the medical community will allow increased use of automated medical review edits for denial of claims that fail policy tests. 3) HCFA will install off-the-shelf and correct coding edits to enhance detection of improper claims.

- HCFA – The Medicare Secondary Payer (MSP) provisions require other insurers to pay first (primary) to Medicare under certain circumstances. MSP program efforts include both pre-pay and post-pay activities. While HCFA's preferred approach is a preventive approach, liability and no-fault situations are more likely to involve post-payment recoveries. Unlike, for example, group health plan (GHP) situations, where Medicare will not pay if it is aware of the group health plan coverage, Medicare is required to make conditional payments if the applicable liability or no-fault insurance will not make prompt payment. A concentrated educational and outreach program focusing on liability and no-fault MSP recoveries is expected to increase liability and no-fault dollar recoveries both over the short term and into the future.

Selected FY 2000 Performance Goals and Measures

- Reduce the percentage of improper payments made under the Medicare Fee-for-Service program. FY 2000 measure: To reduce the error rate for all Medicare fee-for-service payments to 7 percent by the year 2000 and 5 percent by the year 2002 and develop a new methodology by 2000 in order to project a more precise error rate which is statistically valid below the national level (i.e., at the benefit category, provider, and/or contractor levels). *HCFA Plan*

- Improve the efficiency of the medical review of claims. FY 2000 measure: Conduct medical review on an additional 10% of the baseline number of 91 million claims that would have been reviewed given current efficiency levels and funding amounts. *HCFA Plan*

- Increase the ratio of recoveries to audit dollars spent. FY 2000 measure: The target for FY 2000 is a $13 to $1 savings ratio. *HCFA Plan*

- Increase Medicare Secondary Payer liability and no-fault recoveries. FY 2000 measure: Increase Medicare Secondary Payer liability and no-fault dollar recoveries by five percent. In addition, HCFA will develop a methodology for measuring liability and no-fault leads. *HCFA Plan*

- Reduce the percentage of Medicare home health services provided for which improper payment is made. FY 2000 measure: Reduce the percent of home health services provided for which improper payment is made is made from 35 percent to 10 percent in California, Illinois, New York, and Texas. *HCFA Plan*

- Ensure Millennium compliance (readiness) of HCFA computer systems. FY 2000 Target: All systems necessary to ensure continuity of HCFA payments and other mission critical outputs through and beyond Year 2000 will be millennium compliant. All systems will be certified compliant (mission-critical certified by the independent contractor and others by appropriate HCFA personnel) prior to the need for those systems to process the new dates. *HCFA Plan*

Programs Supporting This Objective

<u>AoA</u>
Research, Training, and Discretionary
<u>HCFA</u>
Medicare
Medicaid
Medicare Integrity Program

HHS 3.6: Improve the Health Status of American Indians and Alaska Natives

From the HHS Strategic Plan, September 1997. The Indian Health Service (IHS) executes the federal government's responsibility, established under law and through treaties, to provide health services for American Indian and Alaska Native (AI/AN) people in remote and inaccessible regions, as well as in more than thirty urban Indian communities. Tribal governments are active partners with IHS in developing and managing programs to meet health needs, and, over the next five years, they are expected to assume an expanding role. IHS and the Department are strongly committed to this new partnership and its potential outcome of improved health for AI/AN people.

The Department and the tribal governments face formidable challenges in accomplishing this objective. AI/AN people have significantly greater health problems than the overall U.S. population. Yet IHS funding for their health services per capita is roughly one-third of what the general U.S. population spends on health care annually. When other sources of funding for AI/AN people are taken into account (Medicare, Medicaid, private health insurance), per capita funding reaches only about two-thirds of the U.S. average. In addition, since FY 1991, IHS has absorbed $245 million in unfunded inflationary costs, which has resulted in a 15 percent reduction in per capita funding for health services (in constant 1995 dollars). As a result, although overall outpatient visits to IHS facilities have steadily increased with the 2.1 percent annual population growth, decreases have occurred in important non-urgent primary services: 23 percent in well-child services since 1991, 14 percent in physical exams since 1994, 18 percent in access to dental services since 1994, and 50 percent in water fluoridation since 1991. These reductions reflect the diversion of limited resources to the increasing demands for urgent care away from the primary services that are critical to long-term health maintenance and improvement.

Key FY 2000 Activities, Initiatives, and Strategies

- Administration Initiative – Providing Quality Care to Native Americans. HHS advances through this budget our efforts to provide quality care to Native Americans. As a whole, they suffer a greater disease burden than other American populations. The $170 million increase for the Indian Health Service (IHS) in FY 2000 provides additional clinical, preventive, and environmental health services, increases contract support payments for those tribes who provide their own health services, and provides for additional maintenance of IHS hospitals and clinics. This investment helps tribes meet their unique health services challenges and reaffirms the Administration's dedication to improving the health status of all Americans.

- IHS – Treatment, Hospitals and Health Clinics. IHS's Hospitals and Clinics Program provides essential services including inpatient care, routine and emergency ambulatory care; and support services including laboratory, pharmacy, nutrition, health education, medical records, physical therapy, nursing, etc. The program includes initiatives targeting special health conditions that affect AI/ANs such as specialized programs for diabetes, maternal and child health, youth

services, communicable diseases (including AIDS and tuberculosis and others), and a continuing emphasis on women's and elder health and epidemiology.

Other clinical services, (dentistry and community services, e.g., public health nursing) along with a number of health programs operated by the tribes (women, infants, and children's programs and behavioral health services) are often housed in the same facilities. This co-location of services in the hospital and clinic increases access and fosters a truly comprehensive community-oriented program.

IHS – Restoring Access to Health Care Initiative. Beginning in FY 2000, IHS will restore access to basic health services, including assuring that there are adequate facilities and equipment for the provision of health services and providing adequate support services to the tribal health delivery system.

IHS – Reducing the Gap in Health Disparities Initiative. IHS will target segments of the population that are particularly vulnerable to disproportionate disease burden: children and youth, women, elders, and urban Indians. IHS will also target the specific disease entities identified as priority areas and responsible for much of the disparity in health status for the AI/AN population. These include dental diseases, injuries, mental health, and cancers. Support for chronic disease prevention efforts and for public health infrastructure are also fundamental to this initiative. This initiative will also support surveillance, prevention, and treatment services and are based on "best practices" defied in the health literature. IHS will also address the need for water and sewer systems for new and existing homes at the community level.

ACF – Native American Programs. ACF's Social and Economic Development Strategies program is based on the premise that local communities have the primary responsibility for determining its own needs, planning and implementing its own programs, and for use of its own natural and human resources. Through a direct grant funding relationship, Tribes and Native communities have created administrative systems to operate their own social and economic programs, much in the same way as State and local governments. Support for the unique, government to government relationship that exists between Tribal governments and the Federal government is reflected in this approach. Additional priority funding areas include native languages preservation and enhancement, environmental regulatory enhancement, and environmental mitigation.

AoA – Grants to Indian Tribes. Grants to Indian Tribes and Native Hawaiian Organizations provides funding to Indian tribal organizations, Alaskan Native organizations, and non-profit groups representing Native Hawaiians to provide supportive and nutrition services, including both congregate and home delivered meals to older Native Americans.

SAMHSA - In collaboration with the IHS, the Center for Mental Health Services funds the Circles of Care program which supports the development and testing of culturally competent models of mental health services for children in Tribes and urban American Indian

organizations. The local communities select the services and outcomes which are important to them locally.

- IHS – Treatment, Indian Health Professions. This program enables AI/AN to enter the health care professions through a carefully designed system of preparatory, professional and continuing educations assistance programs.

- IHS – Prevention, Public Health Nursing (PHN). The public health nursing role is predominantly one of advocacy, strengthening relationships within the Indian community and providing the framework for broadly based community efforts. This includes therapy, counseling, education, and referral activities often carried out in conjunction with other members of the health care teams such as the community health representative. Other significant PHN activities include coordination and case management activities.

- IHS – Prevention, Community Health Representatives (CHR). The CHR program provides an effective bridge between the community and direct health care services to improve and increase access to the health care delivery system. AI/ANs most in need of care are identified and home visits are made to expectant mothers, infants, young children, elderly, and those with chronic diseases. Clinical and preventive appointments are made and transportation is arranged by CHRs to ensure those needing health care services receive the care needed. A full-time national coordinator for community health promotion/disease prevention provides technical assistance to tribal programs and IHS and coordinates activities and resource sharing among the growing number of tribal CHR programs.

- IHS – Prevention, Health Education. IHS will assist its partners to engage in community-based prevention initiatives, such as HIV/AIDS risk behavior, violence prevention, child abuse, physical inactivity, alcohol and substance abuse.

- IHS – Prevention, Anti-Drug Abuse Activities. IHS will increase drug-related activities, including treatment, Adolescent Regional Treatment Centers, Community Rehabilitation and Aftercare, Training/Community Education, Health Promotion/Disease Prevention, Navajo Rehabilitation Program Urban Programs, and Contract Health Services.

  Program improvements will continue to focus on the needs of alcohol and substance abusers who have a history of sexual abuse and on a redesigned community mobilization effort that will provide innovative treatment dn prevention modules targeting communities that have high rates of alcoholism and drub abuse. In addition, IHS efforts will be responsive to changing drug use patterns, such as the increase in methamphetamine use in the Billings Area.

- IHS – Prevention, Injury Prevention. IHS collaborates with tribes and other Federal, State, and local agencies in efforts to reduce the incidence of severe injuries, with special emphasis on primary prevention, developing programs on sound epidemiological bases, and funding community-based prevention projects. IHS has developed injury prevention training programs specifically for the community-based practitioner. IHS will also assist tribes in building their capacity and local tribal health infrastructure to develop effective programs to prevent

traumatic injuries and death and increase the number of tribal injury prevention programs by as many as 200 projects.

OPHS – Executive and Secretarial Orders and Proclamations. OPHS plans to continue its key role in coordination, management, and implementation of several important Executive and Secretarial Orders and Proclamations to address the health needs of AI/ANs. Among them is the departmental minority initiative, under Executive Order 13021 issued in October 1996 to support access by Tribal Colleges and Universities to Federal resources. OPHS will also execute a number of cooperative agreements and other formal arrangements with national and community organizations to address AI/AN health needs, including a cooperative agreement to ensure that AI/AN needs are appropriately addressed in the National Diabetes Education and Prevention Plan.

Selected FY 2000 Performance Goals and Measures

♦ To assess its goal to increase the capacity-building and infrastructure development for tribes and organizations, particularly through the development of codes, courts systems, and the revision of existing Tribal constitutions, ACF will develop a baseline and measure for capacity-building and infrastructure development objectives in each Native American Program. *ACF Plan*

♦ Improve the health and well-being, and reduce social isolation among older American Indians, Alaska Natives, and Native Hawaiians through the provision of community-based services. FY 2000 measure: Increase service provision above the level in Fiscal Year 1995 by 15 percent. *AoA Plan*

♦ By the end of FY 2000, increase by 3% the proportion of I/T/U clients with diagnosed diabetes who have improved their glycemic control over the FY 1999 level. *IHS Plan*

♦ By the end of FY 2000, increase by 3% the proportion of I/T/U clients with diagnosed diabetes and hypertension who have achieved blood pressure control standards over the FY 1999 level. *IHS Plan*

♦ By the end of FY 2000, increase the proportion of women who have annual Pap screening to 55%. *IHS Plan*

♦ By the end of FY 2000, assure that at least 30% of the AI/AN female population 50-69 years of age have had screening mammography during the previous year. *IHS Plan*

♦ By the end of FY 2000, increase by 5% the proportion of AI/AN children served by IHS receiving a minimum of four Well Child Visits by 27 months of age, over the FY 1999 baseline. *IHS Plan*

- By the end of FY 2000, assure that the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth is increased by 5% over the FY 1998 GPRA Dental Pilot Dental Project level. *IHS Plan*

- During FY 2000, increase by 3% the proportion of AI/AN children who have completed all recommended immunizations by the age two over the FY 1999 rate. *IHS Plan*

- By the end of FY 2000, increase overall pneumococcal and influenza vaccination levels among adults aged 65 years and older to 60%. *IHS Plan*

- By the end of FY 2000, halt the continued increase of obesity in AI/AN children age 2-4 years in at least six pilot intervention sites at FY 1999 rate, through the effective implementation of the intervention developed in FY 1999. *IHS Plan*

Programs Supporting This Objective

ACF
Native American Programs
AoA
Grants to Indian Tribes
IHS
Treatment
  Hospitals & Health Clinics
  Dental Services
  Mental Health
  Alcohol & Substance Abuse
  Contract Health Services
  Urban Health
  Indian Health Professions
  Tribal Management
  Self Governance
  Contract Support Costs
Prevention
  Public Health Nursing
  Health Education
  Community Health Representatives
  Environmental Health Support
  OEHE Support
Capital Programming/Infrastructure
  Sanitation Facilities
  Health Care Facilities Construction
  Facilities Support
  Environmental Health Support
  OPHE Support
  Equipment
Consultation, Partnerships, Core Functions, and Advocacy
  Direct Operations
  Facilities Support
  Environmental Health Support
  OEHE Support
OPHS
SAMHSA
Knowledge Development and Application
National Data Collection State Infrastructure
Substance Abuse Block Grant
Mental Health Performance Partnership Block Grant

HHS Goal 4: IMPROVE THE QUALITY OF HEALTH CARE AND HUMAN SERVICES

From the HHS Strategic Plan, September 1997. Together with partners in state, local and tribal governments, the Department of Health and Human Services (HHS) is responsible for delivering an array of health and human services designed to improve the health and economic and social well-being of its citizens. Attendant upon this responsibility is the need to improve the quality of these services continually in order to enhance their effectiveness. The Department accomplishes this through support for a wide range of quality improvement activities designed to provide better ways of addressing the constantly changing problems that confront the health and human service delivery system, from changes in family structures and demographics to innovations in the way health services are organized and financed.

Health Care Services. America is justifiably proud of the quality of care available from its health care system, which over the past fifty years has produced dramatic improvements in the prevention and effective treatment or cure of many diseases and, in turn, longer life spans and more productive lives. These advances were supported in large part by the fee-for-service financing of the health care system. However, a continuing escalation of health care costs in the fee-for-service system set the stage for the transformation that is now occurring in the financing and delivery of care. The demands of purchasers for better value in health care have fostered a variety of strategies and interventions, now often described in the aggregate as managed care, which have brought utilization controls and competitive forces to bear on the industry. Such changes, along with payment reforms in Medicare, have helped curb the rate of growth of health care expenditures.

At the same time, concerns have arisen that cost reductions might compromise the quality of care. Studies have found that many patients do not receive the most appropriate treatment because of underuse or overuse of certain therapies. Assessments are difficult, however, since national baseline information on the quality of health care is at the developmental stage and consumers often erroneously equate restrictions on choice with diminished quality.

In addition, the role of patients in the health care system is changing. In contrast to earlier practice, individuals are being asked to make choices about their health care plans, health providers, and even specific therapies. Many have responded to this change by demanding information about health plans, providers, delivery systems, and treatment options and products. Yet, most consumers have never seen information on quality of care, and when they have seen it, they were not sure how to use it. In addition, wide disparities in access to quality health care persist for certain groups, notably the economically disadvantaged and racial and ethnic minority groups, and contribute to important differences in health status and outcomes.

HHS influences the quality of health care in this country in many ways. Medical research sponsored by the National Institutes of Health (NIH) develops the knowledge base for clinical and population-based health services. From research sponsored by the Agency for Health Care Policy

and Research (AHCPR) have come new measures of health outcomes and quality performance, and studies of the effectiveness of both medical services and of ways to improve and assure quality of care. Multiple agencies—NIH, AHCPR, HCFA, HRSA, IHS, and SAMHSA—develop and disseminate information on how that knowledge can be most effectively applied in various specialized settings. The Department is the largest purchaser of care in the United States through the Medicare and Medicaid programs and through its grant programs to states, tribal governments, and nonprofit entities such as community health centers. The Health Care Financing Administration (HCFA) develops standards and certification of providers, clinical laboratories, and health plans, and has been a leader in the development of performance standards and quality measures for health plans. These standards ensure the basic quality of care for all Americans. Through the Food and Drug Administration's (FDA) regulation of drugs, biologics, and medical devices, and the quality of information disseminated about them, the Department ensures the safety and efficacy of these critical components of medical practice. Also, the Department directly provides health care to Native Americans through the Indian Health Service (IHS). Furthermore, HHS influences practitioners and consumers through the dissemination of health information to these audiences.

Human Services. Human services delivery systems are currently undergoing enormous changes that place new demands on the Department's ability to provide quality services. HHS' role includes assisting states and other partners to develop their data and evaluation capacities and providing extensive technical assistance to help its partners in state and tribal governments and in communities to have access to current information on how to provide high quality and effective social services. The Department will support both research and demonstrations to expand the knowledge base; to identify best practices to help inform states of extant models and approaches to improve the quality of job services, transportation, and child care services; to help identify those who would not otherwise succeed in work without ancillary human services; and to help improve the integration and quality of the services to enable and sustain employment.

Breaking the cycle of dependency depends both on work with parents and early interventions on behalf of children. The Head Start program was established in 1968 to provide comprehensive services to preschool children. In recent years, the program has been expanded to serve more low-income children. Program expansion has heightened awareness of the importance of quality services even further. Recent research in related disciplines is helping to sharpen understanding about early intervention and its effects on early growth and development. The program has had a long history of monitoring and program improvement. But even more is needed to develop effective measures of quality and performance in Head Start, Early Head Start, and child care programs. The Department will continue to work collaboratively with national organizations, researchers, and local programs to develop measures. Rigorous study has commenced to measure Early Head Start outcomes, and child care research partnerships will be expanded to conduct field-initiated studies to examine issues of quality, among other issues.

In related efforts, the National Institute of Child Health and Human Development (NICHD) has conducted a national study of the effects of child care on child development. The increasing demand for child care services for welfare and low-income families has begun to be met with modest increases in funding for subsidized child care. However, little is known about how far the

subsidy monies can be extended, the quality of child care that can be purchased with the amounts available, the supply and nature of child care available, utilization patterns, or the extent to which variations in subsidy and quality child care affect labor force attachment. The Administration for Children and Families (ACF) has initiated activities to improve the Department's understanding of the demands for child care, the child care market, and methods for assessing quality to help inform parents in their choices of care. The quality of license-exempt, unregulated family day care is of particular concern since this is frequently the choice of low-income families. Additional study will soon commence to examine the nature and effects of such care on children and on their parents' ability to enter and sustain employment.

Through these and other interventions, HHS plays an important role in enhancing the development and application of research based on quality standards in the field of human services.

In both health care and human services, the strategies outlined for this goal should be considered partial and preliminary. The Secretary has identified ensuring the quality of health and human services as one of the Department's highest priorities for the next five years, and is leading several planning processes to refine the Department's strategies and translate them into action. Elements of those strategies are described in the objectives that follow. However, they are expected to evolve significantly over the next two years and to be influenced by the recommendations of groups such as the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

HHS 4.1: Promote the Appropriate Use of Effective Health Services

From the HHS Strategic Plan, September 1997. Many health care services known to be effective are not used for all who could benefit. For example, only 21 percent of patients who have a heart attack receive the beta-blocker medication known since the early 1980s to reduce mortality. Patients with depression frequently are not diagnosed and treated effectively. Asthma guidelines published by the NIH in 1991 strongly recommend the use of inhaled steroids, but subsequent increases in the use of this medication have been quite modest—from 10 to 15 percent. A substantial portion of hospital admissions for children with gastroenteritis, the fifth leading cause of hospital admissions for children under age 5, could be avoided if oral rehydration therapy were prescribed in a timely fashion.

Significant improvements in health, as well as reductions in costs associated with unnecessary or remedial care, could be achieved by improving the extent to which physicians and other practitioners deliver the most appropriate treatments.

Key FY 2000 Activities, Initiatives, and Strategies

- Administration Initiative – Promoting Educational Excellence in Children's Hospitals. The HHS budget proposes $40 million to support graduate medical education at free-standing children's hospitals. These hospitals play an essential role in the education of our physicians. They train 25 percent of all pediatricians and over half of many pediatric subspecialties.

- Administration Initiative – Improving Asthma Treatments. The President's Budget proposes $50 million in demonstration grants to States for testing innovative asthma disease management techniques for children enrolled in Medicaid. This would help those children receive the most appropriate care to control their asthma. Participating States will measure the program's success in averting asthma related crises such as decreased emergency room visits and hospital stays to judge the success of the project in improving asthmatic children's quality of life.

- FDA – FDA is responsible for ensuring that drugs, biologics, medical devices and food are safe, effective and appropriately labeled. In addition to reviewing new drugs, biologics, medical devices and food additive products, FDA plays a key role in disseminating information about these new products to health professionals and in ensuring the correct use of these products.

  FDA continues to collaborate with industry to inform physicians, patients and consumers about new drugs and food items. In FY 2000, FDA will continue to make information about newly approved products, product labels, correct use of medications, and risk information about FDA-regulated products available on the Internet to health professionals, consumers and other interested persons. FDA also has an outreach program for physicians to inform them of new

drugs available to their patients. Information is also available on new therapies approved by foreign countries before the FDA approves them.

- CDC – Epidemic Services. Epidemic services cover a vast spectrum of activities: preventing and controlling epidemics and protecting the U.S. population from public health crises including biological and chemical emergencies; developing, operating, and maintaining surveillance systems, analyzing data, and responding to public health problems; training public health epidemiologists; developing leadership and management skills of public health officials at the federal, state, and local levels; carrying out the quarantine program as required by regulations; and publishing the *Morbidity and Mortality Weekly Report*, CDC's main channel for communicating public health news about disease outbreaks and trends in health and health behavior.

- FDA – Although FDA-regulated products are rigorously tested during the premarket review period, certain rare adverse effects of products are not recognized until after a product is in widespread use. When new health risks related to FDA-regulated products are recognized, FDA ensures that manufacturers, health professionals, and consumers are alerted and corrective actions are taken.

  MedWatch, the FDA Medical Products Reporting Program, is an initiative designed both to educate all health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events and problems to FDA and the manufacturer; and to ensure that new safety information is rapidly communicated to the medical community and that patient care improves as a result. FDA uses a variety of means to provide feedback to the health care community about safety issues involving medical products, including "Dear Health Professional" letters, safety notifications, product recalls, and product label changes. These are available on the Internet and in print.

- HCFA – Appropriate use of effective medical services is a critical component of HCFA's focus on Medicare beneficiaries. HCFA's efforts to improve medical treatment through its collaboration with Peer Review Organizations is the basis for its performance goals to: 1) improve heart attack survival rates, 2) increase influenza vaccination, and 3) increase the use of mammograms. PROs, which serve under contract with HCFA, conduct cooperative improvement projects in which they use data to identify opportunities to improve care, and then work to develop interventions that will bring improvement for subject quality indicators. Pertinent to the HCFA performance plan, HCFA and the PROs are fostering utilization of interventions to treat heart attacks and improve survival rates; are working with providers, health plans and others on influenza vaccination projects; and are networking with local project collaborators to provide education and reminders to improve mammography rates.

- HCFA – The central importance of childhood immunization is recognized by the Children's Health Insurance Program (CHIP). Under the legislation, States that create a separate CHIP program must include coverage of the complete series of immunizations. States also are prohibited from imposing co-payments or deductibles on immunization services. Almost all of the CHIP State Plans submitted to HCFA by April 1998 indicated the intention to apply a

measure of childhood immunization to their CHIP population as a basic indicator of quality of care.

Moreover, highly effective, evidence-based interventions are available to raise childhood immunization coverage levels. A large number of studies have shown that performance measurement through HEDIS®, registries, or other assessment techniques and the use of recall and reminder systems to identify and track children in need of vaccination will substantially raise coverage levels. A major barrier to childhood immunization is the information gap that exists among parents and providers about the immunization status. Research indicates that over three-fourths of parents of children in need of immunization believe their child is completely vaccinated. Similarly, providers also tend to greatly over-estimate the immunization coverage levels of their patients. This information gap is an important reason why both performance measurement and recall and reminder systems are highly effective, evidence-based intervention strategies that are recommended by both the Centers for Disease Control and the Advisory Committee on Immunization Practices.

- HRSA – Primary Care, Health Centers. HRSA's Health Centers provide psychosocial support and enabling services such as outreach, home visiting, case management, transportation, translation, health education, and eligibility determination. These services, which may not be covered by public or private insurance, are geared to facilitate timely entry into care and appropriate use of the health system.

- CDC – To ensure the scientific foundation of public health practices, CDC coordinates the development of the *Guide to Community Preventive Services*. This *Guide* provides public health practitioners, their community partners, and policy makers with evidence-based recommendations for planning and implementing population-based services and policies at the community and state level.

- FDA – FDA is committed to providing clear, up-to-date information to consumers and patients that they need to make health care decisions and to use health products appropriately. The Agency is aware of the growing diversity of consumer health needs and interests. FDA will continue to implement targeted public awareness campaigns such as the *Food Safety Program's BAC!*, *Mammography Awareness Seminars*, and *Over the Counter (OTC) Labeling Changes* and will continue to make information about newly approved products, product labels and a range of health issues available on the Internet in language consumers can understand. The Internet is being used not only to disseminate information to consumers but also to obtain their input on various issues of interest to the Agency. The *FDA Consumer* and other printed materials, many of which are available in several languages, are provided to persons who are without Internet capabilities. A general telephone number and several special interest hotlines are also available to consumers who have specific questions about FDA-regulated products. Public Affairs Specialists in FDA's field offices will continue to play a key role in furnishing up-to-date information about new and emerging products to interested consumers.

- AHCPR – Interim outcomes of research can be evaluated on a relatively short-term basis. However, the ultimate outcome of how the research affects people receiving health care or

people interacting with the system requires large, expensive retrospective studies. AHCPR is implementing a growing portfolio of evaluations that will show over time the outcomes of the investments of Agency funds. The FY 2000 strategy involves assessing the interim outcomes of four tools created with Agency funds for improving health care quality and evaluating the use and usability of the Medical Expenditures Panel Survey (MEPS) databases for their intended purposes. AHCPR quality improvement strategies that will be subjected to evaluation, and support HHS efforts to promote effective health services include: 1) evidence reports and technology assessments of evidence-based practice centers; and 2) products that advance methods to measure and improve health-care quality, including clinical quality improvement software (CONQUEST), the Consumer Assessment of Health Plans Survey, and the Expansion of Quality of Care Measures project (Q-SPAN).

CDC – CDC focuses on assuring the public's health through the translation of research into effective community-based action. This goal is oriented towards developing the capacity of public health departments to carry out essential public health programs and services, and involve community institutions and community groups in health promotion and disease prevention.

Also, what people understand about their health and potential risks to their health is of major concern in public health. CDC promotes effective health communication, conveying information to appropriate populations, and facilitating access to health information. The agency seeks to enhance the public's health knowledge through communication that is congruent with the values of diverse communities.

CDC will also continue its efforts in the training of public health leaders in the science of public health practice. Training efforts in this area are critical in addressing future public health issues. For example, the CDC-sponsored Public Health Leadership Institute is an ongoing program that develops the leadership skills of public health officials at the Federal, State, and local levels.

OPHS – A comprehensive Surgeon General's report on mental health (the first ever on this area of health care) scheduled for release in FY 2000 will include cutting edge information about the status of mental health research and services within the United States. The report is expected to serve as a basis for shaping the Federal government's future mental health program initiatives, as well as providing the public with valuable information about mental health issues impacting the country. As mental health and mental illness become more main stream and less stigmatized, health insurance coverage is likely be become less restrictive.

SAMHSA – Bridging the gap between research and practice in mental health services and substance abuse prevention and treatment is SAMHSA's goal for continual pursuit of service effectiveness. Knowledge application activities surrounding the goal are intended to further develop and implement results originating in or supported by the National Institutes of Health (NIH) and other organizations. It is the intent of this aspect of SAMHSA's Knowledge Development and Application programs (KDAs) to synthesize knowledge (new or existing)

into forms that are useful to practitioners, effectively creating "best practices" that community-based organizations can use.

In FY 2000, knowledge application mechanisms are prominent throughout SAMHSA's programs, as the following examples indicate.

- The Center for Mental Health Services, following on collaborative research with the National Institute of Mental Health (NIMH), is pursuing effectiveness studies involving the most promising clinical interventions for children, such as wraparound services, multi-systemic therapy, therapeutic foster care, medication therapy for Attention Deficit Hyperactivity Disorder, and behavioral modification training in classroom settings.
- The Center for Substance Abuse Prevention's National Strengthening the Family Initiative includes a dissemination research program that is determining cost effective methods for disseminating information and training on science-based family-focused prevention strategies. The Initiative also includes the Parenting is Prevention Program to strengthen existing anti-drug programs directed by parents, by providing training, technical assistance and resources for parents in initiating youth drug prevention programs.
- The Prevention Enhancement Protocol System collects, synthesizes, translates and disseminates research and practice-based findings in a useable form for application in communities.
- The National Center for the Advancement of Prevention develops, synthesizes, updates and disseminates state-of-the-art prevention knowledge about what works in prevention, for whom, and under what conditions.
- The Center for Substance Abuse Treatment (CSAT) will continue to pursue the application of exemplary treatment models, applying the concepts particularly to women receiving Temporary Assistance to Needy Families, and individuals with co-occurring psychiatric and substance abuse disorders.
- Based on research from the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, the Center will pursue the development of modified treatment approaches to address the needs of special populations and service settings, addressing the impact of factors such as: drug of choice, age, gender, culture, ethnicity, and involvement of other systems such as welfare and criminal justice.

Selected FY 2000 Performance Goals and Measures

- Increase the percentage of Medicaid two-year old children who are fully immunized. FY 2000 measure: Group 1 States (early voluntary setting of baselines and goals) to measure State-specific numerical targets for immunizations for children under two years of age in State Medicaid programs. Group 2 States (all others) will set baselines for Medicaid. [Developmental] *HCFA Plan*

- Decrease the 1-year mortality rate among Medicare beneficiaries hospitalized for heart attacks from 31.4% in 1995 to 27.4% in 2000. *HCFA Plan*

- Increase the percentage of Medicare beneficiaries age 65 years and older who receive an influenza vaccination. FY 2000 measure: HCFA has adopted the Healthy People 2000 goal of

achieving at least a 60 percent influenza immunization rate among non-institutionalized, high-risk populations, including Medicare beneficiaries age 65 and older. *HCFA Plan*

- Increase the percentage of Medicare beneficiaries age 65 years and older receiving a mammogram. FY 2000 measure: Consistent with the Healthy People 2000 goal, HCFA's goals is that 60 percent of Medicare beneficiaries age 65 and older will receive a mammogram in a two-year period. *HCFA Plan*

- Decrease the prevalence of pressure ulcers in long-term care facilities. The development of pressure ulcers is an undesirable outcome that can be prevented in most residents. FY 2000 goal: To establish the baseline, targets, and interventions to accelerate the reduction of the incidence and prevalence of pressure ulcers in long-term care facilities. Baseline: Target date of September 2000 for establishing a baseline. [Developmental] *HCFA Plan*

- Decrease the prevalence of restraints in long-term care facilities. In 2000, the prevalence of the use of physical restraints in long-term care facilities will be reduced to 13 percent. *HCFA Plan*

- Increase the proportion of people with major depressive disorders who obtain treatment to 54% in FY 2000. Baseline: 34% (1992) *OPHS Plan*

- 100% of CDC-funded state diabetes control programs will adopt, promote and implement patient care guidelines for improving the quality of care received by persons with diabetes. Baseline: 60% (1998) *CDC Plan*

- Complete the pilot study of the Multimedia *Morbidity and Mortality Weekly Report* (MMWR) project in which information from the MMWR series of publications is distributed to the media, public, policy makers, and health professionals through multiple media channels — print, television, radio, interactive World Wide Web — using advanced telecommunications technology. *CDC Plan*

- Make new drug approval information increasingly available and targeted and promoted to specific user groups such as consumers, patients, health-care practitioners and industry via the Internet, resulting in a decrease in serious medication errors. *FDA Plan*

- Develop partnerships with eight national organizations to disseminate educational information to consumers about choosing the right medications, taking medicines correctly, and reporting adverse reactions. In FY 1998, two national organizations worked with CDER as partners to develop initiatives and disseminate information. *FDA Plan*

Programs Supporting This Objective

AHCPR
Medical Expenditure Panel Surveys
Research on Health Costs, Quality, and Outcomes
CDC
HIV/AIDS Prevention
Sexually Transmitted Diseases
Tuberculosis
Immunization
Diabetes and Other Chronic Diseases
Heart Disease and Health Promotion
Breast and Cervical Cancer Prevention
Prevention Centers
Infectious Diseases
Lead Poisoning
Health Statistics
Prevention Research
Epidemic Services
Environmental Disease Prevention
Occupational Safety and Health
Eliminating Racial and Ethnic Disparities

FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
HCFA
Medicaid
Medicare
Medicare+Choice
Peer Review Organizations
HRSA
Primary Care, Health Centers
NIH
Research Program
OPHS
Office of the Surgeon General
Healthy People 2000
SAMHSA
Knowledge Development and Application

HHS 4.2: Reduce Disparities in the Receipt of Quality Health Care Services

From the HHS Strategic Plan, September 1997. Disparities in access to health care services and in health outcomes across different groups exist for a variety of reasons—including financial, geographic, cultural, and structural factors, as well as outdated practice patterns and medical uncertainty. The task before HHS is to identify the causes of these disparities and the interventions most likely to reduce and eventually eliminate them.

Whatever their cause, disparities in access to and use of services frequently signal problems in the financing or delivery systems and often translate into poor health outcomes. For example, white patients are more likely than black patients to receive relatively costly interventions such as invasive cardiac procedures; mammography rates for women with less than 12 years of education are one-third lower than rates for other women; black and economically disadvantaged patients are more likely to be discharged in unstable condition, less likely to be placed in intensive care, and less likely to receive thorough interviews and physical examinations.

Key FY 2000 Activities, Initiatives, and Strategies

- Administration Initiative – Reducing Racial Disparities in Health Status. Despite improvements in the Nation's overall health outcomes, minority groups still disproportionally bear the burden of disease and illness. The HHS FY 2000 budget includes $145 million for health education, prevention, and treatment services for minority populations to mitigate the differences in health outcomes. Of this amount, $35 million supports community based research and demonstration projects to reduce health disparities among racial and ethnic minorities.

- HRSA – Primary Care, Health Centers and the National Health Service Corps. HRSA's Health Centers contribute to decreases in health disparities by providing preventive services and risk reduction to a population that is largely minority (65%) and low income (86%). The National Health Service Corps provides a culturally competent workforce for health centers and other sites. FY 2000 strategies focus on:

  Access. HRSA will develop additional primary care access points and serve approximately 9.025 million persons in FY 2000, an increase of 125,000 over FY 1999. HRSA will target new and currently served communities for investment based on health status gaps, unmet need, and potential for increasing access and reducing disparities.

  Racial Disparities. In FY 2000, HRSA will augment Health Center services to focus on disparity reduction, particularly for those communities with the highest morbidity and mortality rates for minority populations. The Health Centers will significantly expand and improve current health disparity reduction efforts that are reducing hospitalization and emergency room

use, reducing annual Medicaid costs, and helping to prevent more expensive chronic disease and disability. The disparity reduction package will include:

- Expanding the counseling of patients regarding tobacco, alcohol, and drug use, oral health, fitness, and nutrition.

- Expanding outreach, home visiting and follow up to assure timely entry into care and appropriate use of the system.

- Adding new staff and training existing staff to focus aggressively on diagnosis, early intervention and state-of-the-art disease management of the conditions targeted in the President's Initiative on Race.

Community-wide activities will be mounted to improve clinical practice and mount community-wide disparity reduction campaigns in partnership with other providers, schools, faith institutions and the private sector.

HRSA – Maternal and Child Health Block Grant. In FY 2000, HRSA will provide additional funds to States to provide services for more the approximately 12 million children who are presently in critical need of multi-disciplinary services and do not have adequate insurance to meet the special needs necessary to develop, function and learn, including optional benefits not provided by some state CHIP plans and urgent treatment and preventive services for children who will continue to be un- and under-insured.

HRSA will also provide assistance and care for some of the new children and critical new needs identified by CHIP outreach that can not be met by Medicaid or State Child Health plans, such as additional translation, case management, transportation, special public health, disability, and gap filling services effective for low-income children. In addition, HRSA will provide vital population-based public health services and support capacity and resource development needed to ensure adequate health care and improved health status of uninsured high risk populations. This program also supports the development of coordinated care delivery systems and services for children with special health care needs.

HRSA – Maternal and Child Health, Healthy Start. Through Title V of the Social Security Act, this program supports projects to develop health care delivery programs and health care services for children in child care programs. It provides the framework and support for newborn screening programs. It also supports the development of coordinated care delivery systems and services for children with special health care needs.

CDC – Eliminating Racial and Ethnic Disparities in Health. CDC efforts will focus on infant mortality, cancer, cardiovascular diseases, diabetes, HIV/AIDS, and adult and child immunization. CDC will also address other areas of preventable health disparities including perinatal conditions, injuries, sexually transmitted diseases, and other infectious diseases. Specific activities include focusing STD and HIV/AIDS prevention efforts in communities of color; conducting applied prevention research, expanding programs, and improving

surveillance aimed at the health problems of racial and ethnic minorities; and improving vaccination coverage levels of adolescents and adults.

- HCFA – To achieve its performance targets for influenza vaccines and mammograms for elderly individuals, HCFA must address the special needs of minority individuals who receive these services to a lesser degree than the population as a whole. Under Horizons, eight Peer Review Organizations are working with eleven Historically Black Colleges and Universities to formulate statewide interventions with a focus on outreach to the African American Medicare population. HCFA will also target nursing home residents for vaccination against influenza–a population at high risk. In order to address the lower mammography utilization rates for African American and Hispanic American Medicare beneficiaries, six Medicare Peer Review Organizations, also under Horizons, are carrying out community-based projects to increase mammography rates in six major cities for these specific populations.

- AoA – Health Disparities Intervention Grants. AoA is proposing to work with CDC in three areas where minority older Americans are disproportionately at risk for preventable and costly chronic disease and disability: cardio-vascular disease, diabetes and immunizations. Grants will bring together the public health and aging networks to influence the lifestyle and behavioral choices of minority elders related to diet, exercise, smoking and immunizations.

- HRSA – HIV/AIDS, HIV Care and Emergency Relief Grants. Recent studies have demonstrated that the benefits provided by the new combination drugs (anti-retrovirals/ protease inhibitors) have not uniformly reduced the incidence of AIDS between genders or racial and ethnic minorities. To this end, HRSA has focused priorities to include increasing access to these vulnerable populations.

- HRSA – Rural Health Outreach Grants. The Rural Health Outreach and Rural Network Development Grant Programs support the delivery of basic health services to millions of Americans living in underserved rural areas of the country.

- IHS – Reducing the Gap in Health Disparities Initiative. IHS will target segments of the population that are particularly vulnerable to disproportionate disease burden: children and youth, women, elders, and urban Indians. IHS will also target the specific disease entities identified as priority areas and responsible for much of the disparity in health status for the AI/AN population. These include dental diseases, injuries, mental health, and cancers. Support for chronic disease prevention efforts and for public health infrastructure are also fundamental to this initiative. This initiative will also support surveillance, prevention, and treatment services and are based on "best practices" defied in the health literature. IHS will also address the need for water and sewer systems for new and existing homes at the community level.

- SAMHSA – As part of SAMHSA's Targeted Capacity Expansion program, an effort has been made to initiate or strengthen the integration of HIV and substance abuse prevention at the local level and increasing local capacity to provide integrated services to African American and Hispanic youth and women. In addition, CSAP's Youth and Women of Color Initiative

continues to identify specific interventions tailored for youth and women of color at risk for substance abuse and HIV disease and to develop strategies with emphasis on reducing known risk factors, increasing protective factors, building resiliency, and addressing multiple risks that cross domains.

AHCPR – Under its FY 2000 priority, "New Research on Priority Health Issues," AHCPR will fund a minimum of 10 projects to address eliminating disparities in health care, with emphasis on disparities that exist for racial and ethnic minorities. Research has shown clearly that disparities in health care exist, but there is a dearth of projects to study how to eliminate them. The following initiatives are to be included under AHCPR's priority in this regard. Through the creation of laboratories for change, AHCPR will build partnerships between health care delivery sites and academic researchers, addressing the specific conditions of racial health disparities. AHCPR will support Health Services Research for Minority Populations and a new program, Minority Health Services Research Centers of Excellence, both focusing on factors that affect quality, cost, outcome and access to care for minority populations. AHCPR will over sample racial and ethnic minorities to enable assessment of the quality of care they receive. AHCPR will develop new tools that are culturally sensitive to minority population needs. AHCPR will train minority and other investigators to address issues for minority populations.

OPHS – The Department's Initiative to Eliminate Racial and Ethnic Disparities in Health targets six areas: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and childhood and adult immunizations. The foundation for the initiative is derived from the goals of Healthy People 2000 and is consistent with the proposed goal to eliminate disparities in health in Healthy People 2010.

Healthy People 2010 will be published in FY 2000. OPHS will examine whether and how the actions adopted in the six areas affect implementation and tracking strategies for Healthy People 2010 for those and other focus areas. Funding would be used for analyses that would look more globally at progress and lessons learned in the short term in all six focus areas, drawing on work done by responsible operating divisions in a specific area; for convening federal partners, national organizations, and other State and local stakeholders to review the findings and replicability of specific aspects of the initiative and identify application to Healthy People 2010; and, as appropriate, to engage other interested parties through active outreach into incorporating these findings into actions addressing other Healthy People focus areas.

OPHS will continue to work with NCHS and HHS components to promote the collection and establishment of baseline and comparison data by race and ethnicity using, at a minimum, the OMB Directive 15 standards.

OPHS – The Minority Community Health Coalition Demonstration Program will continue to support 17 demonstration projects focusing on the reduction of health risk factors in minority populations. Emphasis will continue to be on efforts that can demonstrate effective coordination of integrated community-based screening, outreach, and other enabling services to address health problems and needs of minority communities.

- OPHS – The Office of Minority Health Resource Center will continue to engage in a wide range of activities to inform and educate racial/ethnic minority communities and those who serve them regarding the nature and extent of racial/ethnic disparities in health, policies and programs underway to address such disparities, and actions they can take to improve their health care options. Some of these activities include: assistance in the development of Spanish-language radio broadcast messages to Hispanic communities on health promotion and how to use managed care plans appropriately; provision of Spanish-speaking staff to respond to public inquiries for information and recommendations following such radio broadcasts; and provision of information on and referrals to national organizations of minority health care providers and minority health advocacy organizations that, in turn, provide recommendations regarding local providers.

- OCR – Preventing Discrimination in Access to HHS' Services. Ongoing changes related to increased state flexibility in the organization of health care coverage and services for the poor and disabled receiving Medicaid are likely to continue to expand OCR's responsibilities for ensuring nondiscrimination in the expenditure of federal funds. OCR will concentrate its resources on the critical civil rights issues surrounding changes in health care coverage and services that are undertaken in the states. To focus its compliance initiatives effectively in an increasingly complex and rapidly changing health care delivery environment, OCR will work with its HHS agency partners to improve research and data collection efforts to support targeted enforcement in this changing arena.

  The paradox of managed care for vulnerable populations is that, although such arrangements have the potential to improve access for minority and disabled populations, the underlying premise of managed care is control of over-utilization of services. Because managed care may be predicated, in part, on a belief in "excess" care, such systems raise important issues for populations for whom under-service rather than over-utilization has been the historic problem. OCR will focus on assessing the effects of managed care on services to minority and disability communities.

  In addition, OCR will continue to work with health care and social services providers, state and local agencies and HHS partners, to ensure that persons of limited English proficiency are not discriminated against on the basis of national origin.

- OPHS – The Bilingual/Bicultural Service Demonstration Grant Program will continue to support community-based projects to improve access to health care services for limited-English-proficient (LEP) populations. All projects focus on improving the ability of health care providers and other health care professionals to deliver linguistically and culturally competent health care services to LEP populations.

- OPHS –The Center for Linguistic and Cultural Competence in Health develops and evaluates models, conducts research, and provides technical assistance to providers to address the cultural and linguistic barriers to health care delivery and increase limited English speaking individuals' access to health care. FY 2000 activities include: disseminating information on

current language and cultural competency model programs, techniques, organizational and governmental policies; launching a culturally competence systems change initiative; conducting an evaluation of selected sites to determine the effectiveness of culturally competent programs on ethnically diverse patients; commissioning papers on development of culturally competent training programs for health care providers; developing a research project on cultural competence health delivery programs, and initiating research on impact of culturally competent services on patient treatment protocols and outcomes. All products will be disseminated through the Office of Minority Health Resource Center (OMHRC) and through the OMHRC web-site.

Selected FY 2000 Performance Goals and Measures

- Increase the proportion of Health Center women receiving age-appropriate screening for cervical and breast cancer. Targets: Healthy People 2000 objectives of 85 percent for up-to-date Pap tests, 60 percent for up-to-date mammograms and 60 percent for up-to-date clinical breast exams. Baselines: Health Center survey of a representative sample of users comparable to the National Health Interview Survey shows 88.5 percent for up-to-date Pap tests, 62.5 percent for up-to-date mammograms and 80.5 percent for up-to-date clinical breast exams. *HRSA Plan*

- Increase the proportion of Health Center adults with hypertension who report their blood pressure under control. Target: Healthy People 2000 objective of 50 percent. *HRSA Plan*

- Serve women and racial and ethnic minorities in Title II (HIV Care Grants to States) funded programs in proportions that exceed their representation in overall AIDS prevalence by a minimum of five percentage points (e.g., if 15 percent of overall AIDS cases are among women, serve 20 percent women in Title II programs). FY 2000 measures:

  - Total AIDS cases/women: 15.3% (1996)
    HIV Care clients served/women: FY 2000: 27%. Baseline: 26.3% (1996).
  - Total AIDS cases/minorities: 53.8% (1996)
    HIV Care clients served/minorities: FY 2000: 59% *HRSA Plan*

- Reduce the incidence of infectious diseases in racial and ethnic populations by establishing and implementing comprehensive community-based interventions. FY 2000 measure: CDC will conduct community-based research, epidemiologic, behavioral and laboratory investigations including qualitative research and surveillance in collaboration with tribal, US state and local, and Mexican and Caribbean governments to identify causes, currently unknown, for disparities in prevalence of infectious diseases. Baseline: Using disparities in health as baselines to establish objectives, population-based surveillance and community-led strategies will be employed to evaluate the results. (1998) *CDC Plan*

- Develop and distribute baseline incidence data for injury-related health disparity gaps. FY 2000 measure: Expand state-based surveillance systems and outcome surveillance systems in

an effort to gather data previously unavailable for racial/ethnic subgroups. Baseline to be established. *CDC Plan*

- Increase the proportion of Health Center users with diabetes with up-to-date testing of gycohemoglobin. Target: 20 percent of diabetes adults, based on a literature review of mainstream medical practice. *HRSA Plan*

- Decrease the proportion of Health Center users who are hospitalized for potentially avoidable conditions. Target: Developmental, to be determined through review of Medicaid SMRF files and AHCPR Hospital Discharge data. *HRSA Plan*

- Increase the percent of children with special health care needs in the State with a medical/health home. [Developmental] *HRSA Plan*

- Decrease the ratio of the black infant mortality rate to the white infant mortality rate. Baseline: Black rate: 14.0 deaths per 1,000; White rate: 6.0 deaths per 1,000. Ratio: 2.3 (1995 data). [Developmental] *HRSA Plan*

- Increase by 20% the number of unrelated minority bone marrow donors over previous year totals, to 242,000 minority bone marrow donors in FY 2000. *HRSA Plan*

- Increase by 20% over two years the number of minority organ donors nationally from the effective date of the final HCFA Rule on Conditions of Participation of Hospitals to 1,638 minority organ donors in FY 2000. *HRSA Plan*

- Maintain 100% accreditation of all IHS hospitals and outpatient clinics during FY 2000. *IHS Plan*

- By the end of FY 2000, implement an OMB approved IHS -wide consumer satisfaction protocol and determine baseline level of satisfaction with the acceptability and accessibility of health care. *IHS Plan*

- In order to increase access for minorities and persons with disabilities to nondiscriminatory services in managed care plan settings, OCR will increase the number of managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act. FY 2000 measure: 44 corrective actions and no violation findings. Baseline: 10 corrective actions and no violation findings FY 1998. *OCR Plan*

- In order to increase access to HHS services for limited-English proficient (LEP) persons, OCR will increase the number of HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. FY 2000 measure: 140 corrective actions and no violation findings. Baseline: 98 corrective actions and no violation finding FY 1998. *OCR Plan*

- Collect and establish baseline and comparison data for 12 racial disparity measures (coronary heart disease and stroke deaths; incidence of lower extremity amputations and end-stage renal

disease in persons with diabetes), including relevant racial and ethnic subgroups for which no data are currently available. FY 2000 measure: data available for 12 of 12 measures. [Developmental] *OPHS Plan*

Programs Supporting This Objective

AHCPR
Research on Health Costs, Quality, and Outcomes
Medical Expenditure Panel Surveys
AoA
Health Disparities Interventions
CDC
HIV/AIDS Prevention
Sexually Transmitted Diseases
Tuberculosis
Immunization
Diabetes and Other Chronic Diseases
Heart Disease and Health Promotion
Breast and Cervical Cancer Prevention
Prevention Centers
Infectious Diseases
Lead Poisoning
Injury Prevention
Health Statistics
Prevention Research
Epidemic Services
Environmental Disease Prevention
Occupational Safety and Health
Eliminating Racial and Ethnic Disparities
HCFA
Children's Health Insurance Program
Medicaid
Peer Review Organizations
HRSA
Primary Care
  Health Centers
  National Health Service Corps
HIV/AIDS
  HIV Care
  HIV Emergency Relief Grants
  HIV Early Intervention Services
  HIV Pediatric Grants
  Education and Training Centers
  Dental Services Program
Maternal and Child Health
  Maternal and Child Health Block Grant
  Universal Newborn Hearing Screening and Early Intervention
  Healthy Start Initiative
  Emergency Medical Services for Children
  Traumatic Brain Injury Program
  Trauma Care/Emergency Medical Services
Health Professions and Nursing Training Programs
Rural Health
  Rural Health Outreach Grants
  Rural Health Policy Development
  Telehealth
Workforce Information and Analysis
Health Education and Assistance Loans
Organ Procurement and Transplantation
National Bone Marrow Donor Program
IHS
Prevention
Treatment
OCR
Preventing Discrimination in Access to HHS' Services
OPHS
Office of Disease Prevention and Health Promotion
Office of HIV/AIDS Policy
Health People 2000
Office of Minority Health

HHS 4.3: Increase Consumers' Understanding of Their Health Care Options

From the HHS Strategic Plan, September 1997. In a recent poll, 42 percent of Americans said that quality of care is their biggest concern in choosing a health plan, and 39 percent said they had seen quality comparisons within the last year. Although over 80 percent of respondents who had seen quality comparisons indicated they thought such information would be useful in making a decision about health plans, doctors, and hospitals, fewer than 35 percent reported actually ever using such information in their own decision-making. A majority of respondents indicated that their doctor, family, and friends were their most common sources of information on quality and that they would rely on these sources of information rather than on objective quality rankings. Nevertheless, other polls also show that consumers want to be better informed about quality, and many believe they will use information that is accessible and timely.

In the area of health care decision-making, HHS has a critical role to play in helping consumers get and use the information they need. Nearly nine in ten Americans believe government has a role in the quality of health care. Just over half think the government should both monitor health providers to ensure a minimum standard of quality and make sure information about quality is available to the public. By mobilizing and publicizing information resources, HHS can increase consumers' access to information and provide data to supplement the opinions of their friends and family members.

Key FY 2000 Activities, Initiatives, and Strategies

- HCFA – The BBA creates an array of new managed care and other health plan choices for Medicare beneficiaries and establishes a coordinated open enrollment process. These new choices require HCFA to undertake the most extensive beneficiary education program in the Agency's history. It also requires HCFA to develop and implement new prospective payment systems for many Medicare services to help further restrain the rate of growth of health care spending and foster incentives for more appropriate use of scarce program resources. Furthermore, BBA expands health insurance to many uninsured children through the Children's Health Insurance Program (CHIP).

- HCFA – National Medicare Education Program. In November 1998, HCFA is beginning a campaign to educate Medicare beneficiaries so they can make more informed health plan decisions. The initial stages of the campaign focus on increasing access to information about health plan options, as well as increasing awareness among beneficiaries that they now have more health plan options available through Medicare and that they do not have to change from their current option if they do not choose to do so. Later stages of the campaign will focus on increasing understanding among beneficiaries regarding differences between the new health plan options and original Medicare.

AHCPR – The Consumer Assessment of Health Plans (CAHPS) is a tool for surveying members of health plans about their experience with and assessment of the quality of health care they receive, and for reporting the results to other consumers who are choosing a plan. The CAHPS surveys and reports were developed in the first phase of the project, beginning in September 1995 and continuing until January 1997. In the second phase, CAHPS will be enhanced to cover individual health care providers and institutions and to allow for cross-market comparisons of data. Demonstrations will be funded to improve the use of quality information by consumers in public and private settings and evaluate impact in terms of the decisions made by consumers, the changes in consumers' behaviors, and any changes in quality and costs of care as a result of this information. AHCPR will also develop partnerships with appropriate health care organizations to assure that CAHPS products are kept up-to-date and available to both public and private users.

IHS – Office of the Director (OD). OD establishes and coordinates multiple opportunities for American Indian and Alaska Native stakeholders to participate in budget formulation and policy development consistent with the goal of enhancing Indian self-determination.

OPHS – Healthfinder. Usage of the popular consumer health gateway, www.healthfinder.gov, is growing at a rate of 10-15 percent per month and serves users whose information needs range from simple introductory texts to technical resources on diseases, treatments, and health care systems.

OPHS – The Office of Minority Health Resource Center will continue to engage in a wide range of activities to inform and educate racial/ethnic minority communities and those who serve them regarding the nature and extent of racial/ethnic disparities in health, policies and programs underway to address such disparities, and actions they can take to improve their health care options. Some of these activities include: assistance in the development of Spanish-language radio broadcast messages to Hispanic communities on health promotion and how to use managed care plans appropriately; provision of Spanish-speaking staff to respond to public inquiries for information and recommendations following such radio broadcasts; and provision of information on and referrals to national organizations of minority health care providers and minority health advocacy organizations that, in turn, provide recommendations regarding local providers.

Selected FY 2000 Performance Goals and Measures

♦ HCFA will ensure that in FY 2000, 80% of Medicare beneficiaries have at least on managed care choice. *HCFA Plan*

♦ Increase the percentage of beneficiaries who are satisfied with the health care services they receive through the Medicare program. [FY 2000 measure: developmental] *HCFA Plan*

♦ Improve the effectiveness of dissemination of Medicare information to beneficiaries. FY 2000 measure: In FY 1999, HCFA will set the targets for FY 2000 in terms of two measures: 1) the percentage of beneficiaries who were able to obtain information about their health plan choices

when they needed it, and 2) the percentage of beneficiaries who are aware that Medicare now offers a number of different health plan choices in addition to traditional Medicare. [Developmental] *HCFA Plan*

- By the end of FY 2000, the IHS will have improved the level of consultation and opportunities for participation for its I/T/U partners as demonstrated by a 5% increase in score over the FY 1999 satisfaction survey. *IHS Plan*

Programs Supporting This Objective

AHCPR
Research on Health Costs, Quality, and Outcomes
HCFA
Medicaid
Medicare
Medicare+Choice
IHS
Office of the Director
OPHS
Office of Disease Prevention and Health Promotion

HHS 4.4: Improve Consumer Protection

From the HHS Strategic Plan, September 1997. As the Department becomes more cost conscious, health plans can play an important role in helping it move from a health-care-on-demand mind set to one in which care is given when medically necessary or to prevent illness. However, because such attention to the effectiveness of care is a relatively new phenomenon, clinical knowledge may yet be insufficient to support evidence-based treatment protocols. The line between appropriate management of care and inappropriate denial of access to necessary care is not always clear cut. In light of this ambiguity, the imperative to reduce costs makes consumers wary of the care management practices of health plans. Yet, while consumers should be protected from clearly inappropriate practices, health plans should remain free to develop new clinical and management protocols. By the same token, services of questionable quality that are provided in a fee-for-service setting continue to arouse concern because of their possible adverse outcomes and unnecessary costs for consumers, insurers, and public programs providing insurance coverage. As plans of all types look for ways to provide health care more efficiently, consumers face a multitude of process requirements (such as prior authorizations) and choices about how to obtain their coverage (for example, whether to use the local pharmacy or the plan's mail order pharmacy). These choices may have substantial financial implications. As health plans become more complex and more varied, information about how they operate is essential if consumers are to exercise their rights and make decisions that best meet their needs. And, as different types of provider arrangements proliferate, consumers need to become more aware of financial and contractual relationships between providers and the health plans."

Key FY 2000 Activities, Initiatives, and Strategies

HCFA – Medicare Summary Notice (MSN). To enhance their understanding of their Medicare benefits and reduce beneficiary confusion over what Medicare covered for their services, HCFA is continuing its nationwide implementation of the Medicare Summary Notice (MSN). The MSN combines information sent to Medicare beneficiaries on benefits received under Medicare Part A and Part B into easy-to-read monthly statements.

HCFA – The appeal process is a critical safeguard available to all Medicare beneficiaries, allowing them to challenge denials of payment or service. The appeal process takes on added significance in managed care and other Medicare Plus Choice plans where there can be pre-service denials of care and, thus, the possibility of restricted access to Medicare covered services. Over a 3-year period beginning in 1998, HCFA will start development of a comprehensive appeal data system to collect internal plan appeal data in order to hold plans accountable for their performance and in 2000, the system will be used to supply baseline data on several indicators of plan performance.

HCFA will initiate a number of interventions to promote improved performance, including establishing higher standards through changes to the contractor performance requirements; collecting and sharing information on best practices, through mechanisms such as workshops

and regular contractor call center user group conference calls; providing funding increases, if funds are available; and monitoring contractor performance and using our legal authority as appropriate when contractors fail to meet HCFA standards.

- AoA – Long-Term Care Ombudsman. States will be encouraged to develop targeted ombudsman program strategies which are prevention and public health education oriented. Data from the National Ombudsman Reporting System will be used to identify the quality of care problems that can be averted through preventive interventions.

- HCFA – Medicare Telephone Service Improvement. Medicare contractors handle in excess of 18 million telephone inquiries annually from beneficiaries and other callers. Beneficiary telephone customer service therefore clearly is a central part of HCFA's customer service function and directly supports the strategic plan goal to promote beneficiary and public understanding of HCFA and its programs. HCFA provides for telephone customer service through a variety of sources. A very large part of the overall volume of calls is handled by Medicare carriers. This goal focuses on improving the telephone customer service of Medicare carriers. A thorough assessment of carrier telephone customer service requires measurement along three dimensions: accessibility of the service, accuracy of response, and caller satisfaction. HCFA intends to adopt a long-term view in measuring and improving carrier telephone customer service.

- HCFA – HCFA and other groups have sponsored a large number of provider and consumer education projects to demonstrate ways in which nursing homes may remove residents' restraints. These projects have demonstrated that restraint removal improves quality of life and quality of care and actually decreases the risk of resident injury. HCFA has actively sponsored and participated in education programs consisting of seminars presented locally throughout the country and via satellite to nursing home providers, care givers and residents' families; interactive video training programs; and written manuals.

  One of the main ways in which HCFA can promote reduced use of physical restraints is through the State Survey and Certification Program. State and HCFA surveyors who conduct annual inspections of nursing homes pay close attention to nursing homes' use of restraints and cite nursing homes for deficient practices when they discover that residents are restrained without clear medical reason.

- HCFA – HCFA is committed to sustaining the current level of accuracy for diagnostic laboratory tests regulated under the Clinical Laboratory Improvement Amendments (CLIA). Specifically, HCFA commits to sustaining the improvements obtained thus far in laboratory scores on proficiency (accuracy) testing (PT) while maintaining the rate of compliance with PT enrollment requirements in CLIA. It is important to measure both enrollment and PT scores so that all laboratories subject to PT under the CLIA rules are both continuing to participate in a PT testing program and continuing to perform well on those PT challenges**.**

  Interventions in place from which the improvement has occurred and will continue to be maintained with respect to test accuracy include:

- laboratories reviewing their own findings of PT performance and taking appropriate actions in their laboratory to correct the problem

- State surveyors and HCFA-approved accrediting bodies employing an educational, outcome oriented survey approach and ongoing monitoring of laboratory PT performance

- recommending training and technical assistance for laboratories that fail to meet the standards set for PT performance in lieu of sanctions for the first occurrence

- not allowing laboratories refusing training and technical assistance to conduct the test(s) in question until they have met two PT challenges successfully

- taking enforcement actions or sanctions if a laboratory's accuracy does not improve or is so poor as to pose a threat to the public health and safety

- requesting PT providers to be available to assist laboratories that fail PT to determine why they failed and to prevent recurrence.

IHS – Treatment and Prevention. The IHS and its Tribal and Urban Indian Program partners have committed to maintaining excellence in the services provided to consumers through systematic quality assurance processes and bench marking with the standards of the industry.

ACF – Developmental Disabilities. ACF and its partners will continue to protect the legal and human rights of individuals with developmental disabilities.

ASPE – Policy Research. Many states and communities are undertaking or considering significant changes in the delivery of health and human services, including health insurance coverage, performance-based services, comprehensive services for children, assisted living and other services to help adults with disabilities. With the ever increasing changes in the delivery of services, it is critical to assess the impact and measure the effectiveness of these expansions. ASPE supports studies that fill gaps in HHS' ongoing research plan.

OPHS – OPHS will continue to be integrally involved in the work of the Goal 6/Consumer Protection Work Group under the Secretary's Health Care Quality Improvement Initiative and the various work groups under the Quality Initiative Coordination (QuIC) Task Force. OPHS will continue to support the development and implementation of Departmental initiatives that promote cultural competency as a consumer protection for increasingly racially and ethnically diverse populations in the U.S. as well as of HHS efforts to comply with the Consumer Bill of Rights and Responsibilities, per Executive Order. OPHS will also support studies that assess the impact of culturally competent health care services on racial and ethnic minority populations.

OCR – Preventing Discrimination in Access to HHS' Services. Ongoing changes related to increased state flexibility in the organization of health care coverage and services for the poor and disabled receiving Medicaid are likely to continue to expand OCR's responsibilities for

ensuring nondiscrimination in the expenditure of federal funds. OCR will concentrate its resources on the critical civil rights issues surrounding changes in health care coverage and services that are undertaken in the states. To focus its compliance initiatives effectively in an increasingly complex and rapidly changing health care delivery environment, OCR will work with its HHS agency partners to improve research and data collection efforts to support targeted enforcement in this changing arena.

The paradox of managed care for vulnerable populations is that, although such arrangements have the potential to improve access for minority and disabled populations, the underlying premise of managed care is control of over-utilization of services. Because managed care may be predicated, in part, on a belief in "excess" care, such systems raise important issues for populations for whom under-service rather than over-utilization has been the historic problem. OCR will focus on assessing the effects of managed care on services to minority and disability communities.

In addition, OCR will continue to work with health care and social services providers, state and local agencies and HHS partners, to ensure that persons of limited English proficiency are not discriminated against on the basis of national origin.

Selected FY 2000 Performance Goals and Measures

- Improve Medicare Managed Care Plans' administration of the appeal process. FY 2000 measure: Have a functioning data system in place for collection of plan level appeal data. Collect baseline data on the 6 measures and develop estimated targets for future years. *HCFA Plan*

- Decrease the prevalence of pressure ulcers in long-term care facilities. The development of pressure ulcers is an undesirable outcome that can be prevented in most residents. FY 2000 goal: To establish the baseline, targets, and interventions to accelerate the reduction of the incidence and prevalence of pressure ulcers in long-term care facilities. Baseline: Target date of September 2000 for establishing a baseline. [Developmental] *HCFA Plan*

- Decrease the prevalence of restraints in long-term care facilities. FY 2000 measure: Decrease the prevalence of the use of physical restraints to 13 percent. *HCFA Plan*

- Sustain improved laboratory testing accuracy. FY 2000 measure: HCFA will sustain the following levels to be achieved by the end of FY 1999: 1) 90 percent of the total scores reported from all laboratories enrolled in performance testing will contain no failures; and 2) the percentage of Clinical Laboratories Improvement Act laboratories properly enrolled and participating in performance testing will increase to 95 percent. *HCFA Plan*

- Assist residents, families, friends and others to resolve problems related to care and conditions in long-term care facilities. FY 2000 measure: Maintain 71.48% national resolution/partial resolution rate. *AoA Plan*

- Improve both access and quality of telephone customer service provided to beneficiaries. FY 2000 measures:

  - The telephone busy rate for Medicare carriers will be lowered, the number of Medicare carriers who answer calls within 2 minutes will increase and the number of carriers who answer 80 percent of incoming calls within one minute will increase (all baselines will be available in 2000 and HCFA will set targets by 2001).

  - Measures to increase the accuracy of carrier response and increase caller satisfaction with information beneficiaries receive will be developed. [Developmental] *HCFA Plan*

- Maintain 100% accreditation of all IHS hospitals and outpatient clinics during FY 2000. *IHS Plan*

- In order to increase access for minorities and persons with disabilities to nondiscriminatory services in managed care plan settings, OCR will increase the number of managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act. FY 2000 measure: 44 corrective actions and no violation findings. Baseline: 10 corrective actions and no violation findings FY 1998. *OCR Plan*

- In order to increase access to HHS services for limited-English proficient (LEP) persons, OCR will increase the number of HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. FY 2000 measure: 140 corrective actions and no violation findings. Baseline: 98 corrective actions and no violation finding FY 1998. *OCR Plan*

Programs Supporting This Objective

ACF
Developmental Disabilities
AoA
Long-Term Care Ombudsman
ASPE
Policy Research
HCFA
Medicaid
Medicare
Research
IHS
Treatment and Prevention
OCR
Preventing Discrimination in Access to HHS' Services
OPHS
SAMHSA
Protection and Advocacy

HHS 4.5: Promote Research That Improves Quality and Develops Knowledge of Effective Human Services Practice

From the HHS Strategic Plan, September 1997. Improving the economic and social well-being of communities, families, and individuals in the United States requires an understanding of the effectiveness of the services being delivered through HHS programs and how it might be improved.

Key FY 2000 Activities, Initiatives, and Strategies

- HHS' evaluation investments are targeted to improve the quality of its services and support the Department's strategic planning, program, and policy development efforts. Performance measurement and data systems monitor progress in achieving program outcomes as well as departmental goals and objectives. In-depth evaluation studies assess the effectiveness of programs and strategies. Environmental assessments are prospective evaluations studies that assess how changes in the larger society affect HHS' programs and strategies. Program management and support evaluations are used to improve the management of health and social services programs and the quality of HHS' evaluation efforts.

- ACF – Projects to evaluate and build on the state waiver evaluations are planned to continue to study and understand the effects of the states' policy and implementation choices in areas of Temporary Assistance for Needy Families (TANF) and other key areas such as child care, child support enforcement and child welfare. There are plans to continue funding rigorous evaluations which will study the impact of family preservation services as they affect permanency decisions for children, the impact of family support services on child abuse prevention and how the Early Head Start program will inform issues affecting child development. Innovations will be tested in adoption practice, kinship care, preventing and treating child abuse and neglect and other areas affecting the well-being of children.

- AoA – Research, Training and Other Discretionary Projects and Programs. AoA is proposing for FY 2000 projects relating to: economic security, with emphasis on pension reform and bettering the status of women in retirement; protection of the older consumer; development and promotion of new roles for successful aging to emphasize continuing productivity; and the demonstration of low-cost interventions for extension of support of caregivers.

- SAMHSA - Knowledge Development programs are designed to examine the effectiveness of models of service delivery in actual settings. In addition to targeting specific concerns such as employment, housing, substance abuse, these programs examine how services are delivered including various integrated services and consumer operated models. Application of effective practices is encouraged through the SAPT and Mental Health Block Grant programs.

- ASPE – Policy Research. Many states and communities are undertaking or considering significant changes in the delivery of health and human services, including health insurance

coverage, performance-based services, comprehensive services for children, assisted living and other services to help adults with disabilities. With the ever increasing changes in the delivery of services, it is critical to assess the impact and measure the effectiveness of these expansions. ASPE supports studies that fill gaps in HHS' ongoing research plan.

- OPHS – OPHS supports several research and service demonstration grant programs and program evaluations to identify what works, model strategies and approaches, and best practices that address the barriers and health problems of racial and ethnic minorities and identify effective disease and disability prevention and public health approaches. Two major grant programs which will continue to be administered by OPHS are the Bilingual/Bicultural Service Demonstration Grants Program to improve access to health care by reducing cultural and linguistic barriers, and the Minority Community Health Coalition Demonstration Grants Program to address reduction of racial disparities in targeted health areas.

- OPHS – The Adolescent Family Life (AFL) program supports demonstration projects to develop models aimed at (1) promoting abstinence from sexual intercourse as a means of preventing adolescent pregnancy and sexually transmitted diseases, including HIV, and (2) assisting pregnant and parenting adolescents, their children and their families. The program also funds research projects examining the causes and consequences of adolescent premarital relations, adolescent pregnancy and adolescent parenting.

Programs Supporting This Objective

ACF
Temporary Assistance for Needy Families
Child Support Enforcement
Developmental Disabilities
Refugee Resettlement
Child Care
Child Welfare
Youth Programs
Developmental Disabilities
Head Start

AoA
Research, Training and Discretionary
ASPE
Policy Research
OPHS
SAMHSA
Substance Abuse Prevention and Treatment Block Grant
Mental Health Services Block Grant
Knowledge Development and Application Program

HHS Goal 5: IMPROVE PUBLIC HEALTH SYSTEMS

From the HHS Strategic Plan, September 1997. Over the past fifty years, the American medical care system has made remarkable gains in saving lives and ameliorating suffering. Clinical medicine, however, is credited with only five of the thirty years that have been added to life expectancy since the turn of the century. Public health interventions have had a far greater impact and, in concert with clinical medicine, will continue to play an important role in achieving the improvements the Department of Health and Human Services (HHS) seeks. The public health system has provided safe drinking water, reduced and even eliminated major infectious diseases such as smallpox and polio, and decreased contamination of the food supply.

State health agencies are working creatively to stretch their resources and support local partners. Yet today, the majority of local health agencies report that they lack sufficient information systems and trained staff to meet current needs. The technology gap is most evident among local health departments, where many staff lack access to or training about computers and electronic information.

In addition, public health agencies are being affected as Medicaid beneficiaries previously served in public clinics are shifted into managed care networks. This shift deprives health departments of the Medicaid support for overhead costs that have helped to sustain basic public health services. Therefore, the shift to managed care heralds a changing role for health agencies, especially the opportunity to concentrate on providing a full range of essential public health services. Doing so, however, will require staff training in population-based services as opposed to direct care. It also presents a challenge to health agencies to address the loss of resources that support basic public health services.

Challenges also exist in the area of food and drug safety. In the drug area, great progress has been made under the Prescription Drug User Fee Act (PDUFA) in making new drugs and biologics available more quickly to the American people. This has been done without compromising the scientific review process; however, more progress can be made, especially with the extension of PDUFA, which is required for continued progress.

Ensuring the safety of the food supply is one of the government's most enduring and important functions. While the United States has the world's safest food supply, major issues need to be addressed, including emerging pathogens, new and novel food ingredients, hazardous dietary supplements, naturally occurring food-borne toxins, and increasing importation of foods. Sources of contamination are more numerous and more varied than the pathogens themselves, highlighting the importance of adequate research, surveillance, and prevention activities. Currently available diagnostic assays for detection of some pathogens have serious limitations, diminishing the Department's ability to ensure the safety of the food supply.

Preserving and improving the nation's public health systems are critical priorities for the Department. Investments in this area will maintain and improve the foundation for effective programs. HHS must work with state and local governments to secure a workforce that is

appropriately trained, information systems that are adequate and effectively linked, and structures and resources that are sufficient to deliver the essential services of public health. The Department also must work with industry and consumers to implement new approaches in science-based regulation that will allow it to protect the food and drug supply while minimizing costs and intrusiveness.

These activities will be coordinated through the Office of Public Health and Science (OPHS) within the Office of the Secretary (OS) and involve the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Food and Drug Administration (FDA), the Health Care Financing Administration (HCFA), and the Administration for Children and Families (ACF).

HHS 5.1: Improve the Public Health Systems' Capacity to Monitor The Health Status and Identify Threats to the Health of the Nation's Population

From the HHS Strategic Plan, September 1997. Monitoring, surveillance, and assessment systems provide the basic information for public health and are fundamental to improvement in the quality of health care. Without timely and accurate data to identify changes and trends in key health indicators, it is impossible to mount effective interventions or to monitor their success. Researchers, policy makers, health professionals, and the public depend on the timely availability of national, state, and local health data. Using such data sources as vital statistics, notifiable disease reports, national health interview surveys, national health and nutrition examination surveys, and national health care surveys, HHS can learn about causes of death, infant mortality, prenatal care, health status and disability, insurance coverage, access to care, health behaviors, diagnoses and treatments, utilization patterns, and many other important health issues. National summary information must be backed by state or regional information to allow the appropriate targeting of resources.

These systems need significant improvements. Data gaps identified by state and local health agencies, CDC staff, and the HHS Data Council (through the Secretary's research initiative regarding transformations in health and human services) must be closed. The lack of capacity to collect data electronically at the community level has been documented by national organizations and individual public health systems. Improvements in this capacity are essential for monitoring changes in the health needs of communities as well as for monitoring the results of community-based health promotion programs. Electronic collection of data (i.e., computer files instead of paper files) at the community level enhances the speed at which data can be analyzed to understand why the health status and health needs of communities are changing. Therefore, investments in electronic monitoring, surveillance, and assessment systems must be a clear priority.

Further, the types of health problems and threats to health have changed dramatically over the past fifty years, in part because of changes in human behavior, increasing international commerce and travel, environmental changes, and deterioration in the public health infrastructure. While polio and smallpox are no longer major threats, their subsidence has not meant a completely net gain for public health. They have been replaced by unintentional injuries, HIV/AIDS, environmentally caused diseases, newly emerging infectious diseases (including food-borne illnesses), and old diseases that are becoming resistant to available drugs. Understanding the changing patterns in risk factors (i.e., human behavior, environmental changes, infectious organisms) are important for developing health programs that *respond* to the changes in health status and health needs of communities. For example, if we know that the rate of asthma is increasing because of increased particulates in air, we can *respond* by developing health promotion programs that address (1) policy and regulation to decrease the amount of particulates; (2) communication with those at risk of asthma about avoiding high risk environments (listening to weather reports, reducing their physical activity levels when particulate levels are high, etc.); and (3) availability of appropriate medical guidelines and interventions.

To meet these new challenges, the Department needs a workforce that is trained to recognize and respond to these emerging public health problems and to use state-of-the-art technology and the most effective prevention strategies available.

Finally, state governments are reorganizing agencies and services to improve service delivery and contain costs; these strategies include rapid expansion of managed care plans serving low-income and medically frail populations. In many cases, this expansion erodes the resources for public health agencies that traditionally serve these clients by eliminating their reimbursement by Medicaid. Whether public health prevention services for these populations will be available in a managed care setting is also a concern.

Of special concern to the Department are public health services for American Indians and Alaska Natives. IHS and other federal funds for the clinical care of Native Americans are being turned over to tribal governments in the process of self-governance. The loss of economies of scale associated with this decentralization to tribes, coupled with IHS experiencing a 15 percent reduction in per capita funding since FY 1991 (in constant 1995 dollars), will make maintaining services and assuring an adequate public health infrastructure particularly challenging.

Key FY 2000 Activities, Initiatives, and Strategies

Administration Initiative – Improving Disease Surveillance. The HHS budget calls for major improvements in public health disease surveillance. Surveillance activities in the infectious disease, food safety, and bioterrorism initiatives ($65 million) would be coordinated into a new National Electronic Disease Surveillance Network. Our Nation currently lacks a standardized, nationwide system for collecting and analyzing epidemiological information on communicable disease outbreaks. This network would establish a strong communication link between the local medical community and the public health sector to provide an integrated surveillance system.

CDC – CDC provides comprehensive information on health including health status, health risks, the health care system, and health-related outcomes. By maintaining a broad-based monitoring capability, CDC can quickly detect and assess public health threats. CDC's assessment capability, epidemiologic and laboratory surveillance, and response capacity ensure a system that identifies health problems and deploys teams of experts to help resolve the problems promptly. Additionally, the assessment and surveillance capacity ensures data for analysis that can help identify causes of disease early and assist in decisions about appropriate research, policy, and programmatic actions.

Emphasis is on assuring that CDC's surveillance and health information systems address current health issues and problems and that existing and new CDC data systems are carefully coordinated and integrated. CDC's Health Information and Surveillance Systems Board stimulates and sponsors innovation in health information and surveillance systems supportive of the essential public health services. In addition, epidemiologic and laboratory capacity for surveillance and response will be strengthened. Making health information available to a wide audience is a major CDC priority that requires adjustments to existing data and surveillance systems and modifications of the procedures for accessing information. For FY 2000, this goal

is accomplished through many of CDC's program activities, with emphasis on Health Statistics, the Preventive Health and Health Services Block Grant, Epidemic Services, and Cancer Registries.

CDC – Public Health Infrastructure Initiative. CDC will establish the systems and improvements needed to protect the public's health in the coming century, specifically:

- CDC will construct needed national laboratories and facilities to replace the unsafe and antiquated structures currently in use.

- CDC will support local health priorities through the Preventive Health and Health Services Block Grant.

- CDC will address unmet prevention research needs in current CDC programs, target specific pressing public health problems, and develop resources to support public health research. One area of focus are the occupational safety and health research gaps identified in the National Occupational Research Agenda, which represents a national consensus on needed research to prevent occupational illness, injury, and death.

- CDC will institute a national Biomonitoring Program to assess human exposure to toxic substances. The program will include the development of a rapid toxic screen; systematic assessments of exposure of the U.S. population to more than 100 toxic substances; and health studies to investigate what substances are actually toxic to people and to determine levels of exposure that cause disease and death.

- CDC will develop a health statistics system for the 21st century which will lead to more integrated and coordinated public health surveillance and information management. This system would address new demands including the devolution of health and welfare programs to the states, advance in biomedical research, health care delivery systems changes, concerns about quality of care, new disparities in health, and changes in data technology and infrastructure.

CDC – Infectious Diseases. CDC's National Center for Infectious Diseases (NCID) will focus on building a strong and flexible public health infrastructure, recognizing that skilled epidemiologists, strong public health laboratories, and coordinated communications and disease reporting systems are essential for developing sustainable disease prevention strategies and are the best defense against any disease outbreak. This approach emphasizes the need for developing emergency preparedness at all levels of government for an organized, rapid, and effective response in the event of pandemics (global epidemics), such as influenza, and large scale disease outbreaks or natural disasters.

In addition, NCID will expand activities of the FY 1998-1999 National Food Safety Initiative. Activities carried out under this initiative have focused on building a national early warning system for hazards in the food supply by enhancing capacity for surveillance and outbreak investigations at the state and federal levels, and by linking state health departments and federal agencies together with sophisticated computer and communications systems to coordinate the response to foodborne disease.

CDC – Preventing Unnecessary Death and Disability from Chronic Disease Initiative. This initiative will include surveillance and epidemiologic research to detect new trends and better elucidate risk factors and their relationships with chronic diseases; applied behavioral, genetic, and occupational research to test new prevention strategies; implementation of comprehensive statewide prevention programs; and national leadership and coordination to mobilize public- and private-sector resources.

  Specific activities will focus on areas that have been severely underfunded and those for which new, promising prevention strategies are available: implement a nationwide strategy to prevent cardiovascular diseases; translate advances in human genetics into disease prevention and health promotion programs; develop a national response to asthma; eliminate the preventable burden of diabetes; reduce the impact of arthritis and osteoporosis; and implement the Fertility Clinic Success Rate and Certification Act.

CDC – Health Statistics. CDC's National Center for Health Statistics (NCHS) provides statistical information to guide actions and policies to improve health of Americans. CDC will build a broad-based health statistics infrastructure needed to meet new demand for health statistics, including saving several "endangered" statistical programs; investing in timeliness and quality; funding initiatives to make data more readily available to users; filling critical gaps in State-level policy-related information; and filling critical gaps in Race/Ethnicity data.

Administration Initiative – Responding to Bioterrorism. HHS is charged with the responsibility to prepare for and respond to the medical and public health consequences of a bioterrorist event. The President proposes for FY 2000 a total of $230 million for HHS to prepare for possible incidents of bioterrorism. As global threats to peace persist, the potential for domestic terrorism in America remains high. Bioterrorism is a pernicious threat because it can affect a large population, go undetected for days or weeks, and cause secondary illness or death if the agent is communicable. Developing surveillance and laboratory capacity to competently and professionally respond to a biological attack is urgent and of the utmost importance.

  Key elements of this initiative include $72 million to improve deterrence, surveillance and communications, establish regional labs for identifying and diagnosing biological and chemical agents, and develop rapid toxin screening. It includes $52 million for the national pharmaceutical stockpile and provides $67.7 million for research and expedited regulatory review of improved drugs and vaccines. The budget also increases funding for local Metropolitan Medical Response Systems to $16.5 million to provide for 25 local emergency medical teams to respond to emergencies involving biological or chemical weapons.

- CDC – Developing a Public Health Response to Terrorism Initiative. CDC will improve public health preparedness at the federal, state, and local levels of government to respond to the threat posed by a terrorist event involving biological, chemical or radiological weapons. CDC will build public health emergency response capacity by building public health surveillance for detecting unusual or small covert events; building epidemiologic capacity for minimizing and controlling potential health threats; enhancing public health laboratory capacity for identifying and diagnosing candidate agents for terrorism; and developing communications systems with other government agencies and the general public for rapidly disseminating information.

- OPHS – The Office of Emergency Preparedness will continue HHS's integrated plan, begun in FY 1999, to address the complex issues of a health and medical response to bio-terrorism, as well as the continued infrastructure for a medical response to terrorism of any type – nuclear, biological or chemical. In FY 2000, OPHS will start 25 new Metropolitan Medical Response Systems (MMRS)and provide bioterrorism capabilities to 27 existing MMRS.

- AHCPR – Monitor quality of care through a strengthened MEPS. AHCPR will increase the capacity of the *Medical Expenditure Panel Survey* (MEPS) to enable the development of a national capacity to monitor the quality of care, particularly for populations of national interest, including the chronically ill, poor, racial/ethnic minorities, and children. Expansion will provide the capacity to: 1) report on the quality of care in America nationally and regionally, and for vulnerable populations; 2) examine quality, cost access, and utilization for people with high-cost illnesses such as hypertension, diabetes and cancer, providing critical data for closing gaps in clinical care as outlined in the President's Race Initiative; and 3) track the national impact of new Federal and State programs, such as the Children's Health Insurance Program, on access and cost of care for children, and compare and evaluate the effectiveness of different strategies to reduce the number of uninsured children and increase access to needed services by those who are covered.

- AHCPR – Redesign of the *Healthcare Cost and Utilization Project* (HCUP). AHCPR will redesign and expand HCUP to provide state and community decision-makers a powerful set of linked databases they can use to monitor the impact of major system changes on access, quality, outcomes and cost in their states and communities, and to compare these against the progress of other states and communities.

- AHCPR – AHCPR will build on past investments in tool development by focusing on expanding the toolbox. These tools will enable purchasers, policymakers, health plans, providers, and patients to improve care. The activities will include: Research to develop and test quality measures with special emphasis on vulnerable populations; research to develop and test new uses of informatics, information technology, and web-based applications to improve outcomes, quality, and the cost, use and access to health care; and research to develop an effective core screening tool that can be used by clinicians in health care settings for early identification and screening of domestic violence patients.

- CDC – Cancer Registries. Through the National Program of Cancer Registries (NPCR), CDC funds States and territories to enhance existing cancer registries; plan and implement Statewide registries where they do not exist; develop model legislation and regulations for States to

enhance viability of registry operations; set standards for completeness, timeliness, and quality; and provide training. The NPCR serves as the foundation of a national, comprehensive prevention strategy; it is a basic tool in surveillance efforts that will provide the needed factual basis for appropriate policy decisions and allocations of scarce resources. As of September 1997, CDC supported 45 States, 3 territories, and the District of Columbia for cancer registries.

CDC – Environmental and Occupational Health. CDC is working to develop cost effective environmental interventions that, in conjunction with improved medical management, will reduce the number of asthma exacerbations and improve the quality of life of people with asthma.

FDA – Injury Reporting Initiative. Reduce injuries and illnesses resulting from consumption and use of FDA-regulated products. One of the FDA's primary objectives is to develop and implement a comprehensive surveillance system to improve the quality of information on adverse events and product defects associated with FDA-regulated products. The system will focus on three areas: surveillance and epidemiology; research; and education and outreach. FDA believes this system will increase the safety of FDA-regulated products because more reports of rare and unexpected adverse events and product problems would be discovered and corrective action taken. Systematic feedback about the problem can then be provided to the healthcare community and the public.

Administration Initiative – Ensuring Food Safety. The HHS FY 2000 budget enhances food safety. HHS funding would increase by $40 million over the 1999 level for the Administration's inter-agency food safety initiative. The FDA, CDC, and the Department of Agriculture will continue to coordinate efforts to ensure a safer national food supply.

FDA – Food Safety Initiative. Surveillance of foodborne illnesses provides critical information to determine the need for preventive interventions. The FoodNet foodborne illness reporting system provides extensive, complete, and reliable information about the occurrences of outbreaks in the U.S. When outbreaks are reported, FDA responds quickly to traceback through the food distribution chain to identify the source of the outbreak and then initiate intervention measures to limit the outbreak. In FY 2000, FDA will add a new site to the FoodNet foodborne illness surveillance system to expand the demographic diversity and size of the population represented and the system's capacity to detect foodborne illness. FDA will also establish PulseNet – an interagency DNA fingerprinting system to monitor the prevalence and diversity of E. coli O157:H7 and Salmonella typhimiurium DT104.

The National Antimicrobial Resistance Monitoring System (NARMS), which detects potential health hazards through systematic collection, analysis and interpretation of antimicrobial susceptibility surveillance data, is a major part of the surveillance component of FDA's Food Safety Initiative. The NARMS is the basis for regulatory decision making, food animal drug policy, and identifying disease trends in human and animal medicine. The NARMS impacts international policy, federal, state, and local programs.

- HRSA – National Practitioner Data Bank. HRSA's National Practitioner Data Bank helps protect the public by assuring that information about medical and dental malpractice payments and other sanctions is available to hospitals and other health care entities, licensing authorities and professional societies.

- HRSA – National Center for Workforce Information and Analysis. HRSA's National Center for Workforce Information and Analysis provides essential data for national, State, and local health workforce policy and analysis. The Center builds a network for health workforce research, forecasts health workforce supply and requirements, and maintains the only source of county-level data across the health professions.

- IHS – Treatment, Indian Health Professions. This program enables AI/AN to enter the health care professions through a carefully designed system of preparatory, professional and continuing educations assistance programs.

- IHS – Information and Telecommunications. This initiative is intended to expand the IHS computing and telecommunication/telemedicine capabilities including enhanced patient record systems and improved monitoring capabilities.

- SAMHSA – SAMHSA's data infrastructure initiative supports the National Drug Control Strategy, and constitutes an important component of performance measurement efforts of the Office of National Drug Control Policy (ONDCP) in determining the impact of Federal, State and local efforts to reduce drug use. The infrastructure at the State and program level is crucial to the production of data to determine client outcomes and program effectiveness. In addition to providing information the initiative moves the substance-abuse field to the implementation of common tools, targets and measures for assessing program effectiveness.

- SAMHSA – Through block grant-related assistance, SAMHSA is working with State substance abuse and mental health agencies to strengthen their ability to collect, analyze and report performance and data to the Federal government.

- NIH – The National Library of Medicine (NLM) collects, organizes, and makes available biomedical science information to investigators, educators, and practitioners and carries out programs designed to strengthen medical library services in the United States. NIH is currently focusing on improved information generation and dissemination by the NLM through initiatives in the following four areas: next generation internet, information services for consumers and patients, basic library services, and outreach.

- OPHS – Healthy People 2010 is scheduled to be released in January 2000 and will provide an agenda for disease prevention and health promotion efforts for the next ten years. To ensure adequate access and to meet the needs of stakeholders for a broad range of information that includes key core indicators, specific content area objectives, and an extensive data tracking mechanism, Healthy People 2010 will be issued as a three-volume set, rather the single volume that comprised Healthy People 2000. The first volume will be designed for policy makers and focus on people, settings, and leading health indicators. It will also be most understandable to consumers. The second volume will contain the national health objectives with supporting

references and justification. This volume will be especially useful to national membership organizations, States and communities to use in developing their own sets of performance measurements. The third volume will be a statistical compendium with the data that describes population groups by gender, race and ethnicity, and socio-economic status characteristics. OPHS will also post Healthy People 2010 on the Internet with a complete searchable text database.

OPHS – US/Mexico Border Health Commission (BHC). BHC is authorized to conduct or support border activities, including a comprehensive needs assessment and investigations, research, or studies designed to identify, study, and monitor, on an on-going basis, health problems affecting the border populations.

The U.S. side of the Commission is expected to be fully operational by FY 2000. Through needs assessments, outreach to border constituencies, and other public interactions, Commissioners will have identified health priorities that could benefit from BHC support and involvement. BHC will provide financial, technical, or administrative assistance to public or private nonprofit entities that act to prevent or resolve such health priority problems. The BHC will also progress toward the conduct or support of a binational, public-private effort to establish a comprehensive and coordinated system for collecting health-related data and monitoring health problems of the U.S.-Mexico border.

OPHS – Office of Minority Health. OMH fosters the development of state infrastructures for addressing minority health issues through the development of a minority health network comprised of Federal, national, state and local organizations. OMH provided assistance through the provision of timely information, conducting of skills-building meetings and conferences (e.g., the use of telecommunications technology), and hands-on technical assistance.

Selected FY 2000 Performance Goals and Measures

♦ Develop and strengthen epidemiologic and laboratory methods for detecting, controlling, and preventing infectious diseases. FY 2000 measures:

- Assays to detect HIV mutations that are resistant to commonly used therapeutic agents will be developed and optimized.

- Six State health departments will be electronically linked with CDC to provide TB results from overseas screening and U.S. follow-up assessments of both immigrants and refugees. Baseline: 0 in 1998. *CDC Plan*

♦ Strengthen domestic and global epidemiologic and laboratory capacity for surveillance and response to infectious disease threats. FY 2000 measures:

- Increase support to 43 states for improving public health infrastructure for surveillance and response. Baseline: 0 States supported (FY 1998).

- 10 regional population-based Emerging Infections Programs will conduct early warning investigations of agents of infectious diseases. Baseline: 9 population-based Emerging Infections Programs. *CDC Plan*

♦ Reduce preventable morbidity and mortality and improve quality of life of people within the framework of Healthy People 2000 by improving the assessment capacity of prevention programs. FY 2000 performance measure: At least 80% of total required data from all programs funded by the Preventive Health and Health Services Block grant will be reported to CDC annually. Baseline: 77% (1995). *CDC Plan*

♦ Ensure safe and healthful working conditions by developing a system for surveillance for major occupational illnesses, injuries, exposures, and health hazard. FY 2000 measure: A comprehensive surveillance planning process will be completed and efforts will begin in implementing recommendations for NIOSH. *CDC Plan*

♦ By 2002, a national network will exist that will provide all states with better access to data on disabilities for their use in analyzing the needs of people with disabling conditions. FY 2000 measure: The number of states who have begun using the Behavioral Risk Factor Surveillance Survey (BRFSS) disability module will be increased to 25. *CDC Plan*

♦ Encourage state health departments to develop efficient and comprehensive public health information and surveillance systems by promoting the use of Internet for surveillance and electronic data interchange, and by focusing on development of standards for data elements. FY 2000 measure: The number of states with a plan for a comprehensive information network will be increased from 18 in 1999 to 22. *CDC Plan*

♦ Establish 3 sentinel networks which will be capable of identifying early victims of biological and chemical terrorism. Baseline: 0 (1998) sentinel networks. *CDC Plan*

♦ Create a national pharmaceutical "stockpile" available for deployment to respond to terrorist use of potential biological or chemical agents, including the ability to protect 1-4 million civilians from anthrax attack. *CDC Plan*

♦ Develop a model metropolitan mental health response plan for a Weapons of Mass Destruction terrorist incident, for inclusion in local disaster preparedness systems. *OPHS Plan*

♦ Increase the number of Metropolitan Medical Response Systems (MMRS) to 60 from 27 in 1998 and provide 27 existing MMRS with bioterrorism capabilities. *OPHS Plan*

♦ Develop Sentinel Surveillance System for device injury reporting based on representative user facilities. *FDA Plan*

♦ Increase the number of local health departments with electronic public health surveillance and secure communications systems to 50. Baseline: 0 (1998) *CDC Plan*

- Establish an integrated adverse event reporting system for food and cosmetic products with emphasis on increasing efforts to design and implement modules needed to record dietary supplement adverse event information. *FDA Plan*

- Work with CDC, the U.S. Department of Agriculture, and States to increase food safety surveillance and to improve responses to foodborne illness outbreaks. *FDA Plan*

- Expedite processing and evaluation of adverse drug events through implementation of the Adverse Events Reporting System (AERS) which allows for electronic periodic data entry and acquisition of fully coded information from drug companies. *FDA Plan*

- Maintain the number of bacterial isolates from human and animal origin in the National Antimicrobial Resistance Monitoring System (NARMS) database to 2,000 and 5,000 respectively. *FDA Plan*

- Establish an electronic data system to facilitate the submission, processing and analysis of error and accident reports for unlicensed blood facilities. *FDA Plan*

- By the end of FY 2000, urban Indian health care programs will have field tested in at least one site, mutually compatible automated information systems which capture health status and patient care data. *IHS Plan*

- By the end of FY 2000, develop and implement an environmental health surveillance system to provide the information needed to identify environmental health issues, establish local and regional priorities, and develop and evaluate environmental interventions and programs. *IHS Plan*

Programs Supporting This Objective

AHCPR
Research on Health Costs, Quality, and Outcomes
Medical Expenditure Panel Surveys
CDC
Health Statistics
Infectious Diseases
HIV/AIDS Prevention
Chronic Disease Prevention
Prevention Research
Cancer Registries
President's Race Initiative
Epidemic Services
Environmental and Occupational Health
FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
HRSA
National Practitioner Data Bank
National Center for Workforce Information and Analysis
IHS
Treatment
Capital Programming/Infrastructure
NIH
Research Program
OPHS
Office of Disease Prevention and Health Promotion, Healthy People 2000
OPHS (continued)
Office of Emergency Preparedness
US/Mexico Border Health Commission, Office of International and Refugee Health
SAMHSA
Substance Abuse and Mental Health Block Grants

HHS 5.2: Ensure Food and Drug Safety by Increasing the Effectiveness of Science-Based Regulation

From the HHS Strategic Plan, September 1997. As a result of the efforts of the Food and Drug Administration and the United States Department of Agriculture (USDA) which covers meat and poultry, Americans have the world's safest food supply and are assured of the safety, reliability, and efficacy of drugs and medical products. FDA not only keeps unsafe or ineffective products off the market but also ensures that valuable products are made available expeditiously. For foods and products already on the market, FDA's role is one of ensuring safety. Its effectiveness in this role is enhanced by surveillance and other programmatic activities conducted by CDC (see strategic objective 5.1).

Although past performance has been impressive, continued attention is necessary. For example, although the U.S. food supply is the safest of those among developed nations, food-borne illnesses still threaten public health and contribute significantly to the escalating cost of health care. Among all the hazards associated with foods, microbes dominate; they account for 90 percent of the confirmed outbreaks, resulting in as many as 33 million illnesses, and 9,000 deaths, and in as much as $3 billion in health care costs every year.

A strong research capacity and the ability to identify and respond to new regulatory challenges have been, and will continue to be, critical factors in FDA's success. That agency's strategic challenge for the twenty-first century will be to maintain the effectiveness of its regulation in a government-wide environment of shrinking resources and increasing demands. By 2002, with expected resources at 70 percent of 1994 buying power, FDA will have a growing workload of complex and diverse new products to review along with increasing amounts of domestic food production and imported food to monitor.

Key FY 2000 Activities, Initiatives, and Strategies

- Administration Initiative – Expanding FDA Resources. HHS proposes to expand resources available to the FDA to comply with the Nation's drug, food, and medical device laws and improve the Nation's adverse event reporting system. The budget increases of $15.3 million for injury reporting, $52.2 million for product safety assurance, and $11 million for premarket application review are necessary for FDA to meet its statutory requirements and public expectations. In addition, $15.3 million invests in preventing product related injuries.

- Administration Initiative – Ensuring Food Safety. The HHS FY 2000 budget enhances food safety. HHS funding would increase by $40 million over the 1999 level for the Administration's inter-agency food safety initiative. The FDA, CDC, and the Department of Agriculture will continue to coordinate efforts to ensure a safer national food supply.

- CDC – Infectious Diseases. CDC's National Center for Infectious Diseases will expand activities of the FY 1998-1999 National Food Safety Initiative. Activities carried out under this initiative focus on building a national early warning system for hazards in the food supply

by enhancing capacity for surveillance and outbreak investigations at the state and federal levels and by linking state health departments and federal agencies together with sophisticated computer and communications systems to coordinate the response to foodborne disease.

FDA – Product Safety Assurance Initiative. To assure that FDA-regulated products are being produced and marketed under conditions that will assure their safety, quality and efficacy. FDA intends to meet its domestic statutory requirement by inspecting domestic firms more often with the assistance of our state regulatory counterparts. The Agency will also use multiple strategies of education, technical assistance, targeting higher-risk industry sectors, and enforcement, when necessary, to correct product risk in the market place. A key element of assuring quality and safety, particularly in the food industry, will be to strengthen the ability of industry to develop its own safety and quality monitoring systems. This will be accomplished, in part, by expansion of the Hazard Analysis and Critical Control Point (HACCP) program from seafood to other appropriate industry segments.

To improve safety of imported products, FDA will continue its three coordinated strategies. First, reduce the probability that violative products will be exported to the U.S.; second, at the U.S. border, make rapid and reliable decisions on product entry; and third, target violative products and prevent their entry into the U.S.

FDA – Food Safety Initiative. To increase consumer confidence in the safety of the nation's food supply. At the federal level, FDA has the primary responsibility for ensuring that foods available to the nation's consumers are safe. Food products, which fall under the regulatory purview of FDA, are estimated to represent 70 percent of those found in the marketplace. The remainder of the food supply, primarily meats and poultry, is regulated by USDA.

The rapid growth in the number and complexity of food safety issues increasingly presents major challenges for FDA, including emerging pathogens, hazardous dietary supplements, pesticides and industrial chemical contaminants. Because of the magnitude and complexity of the hazards involved with these and other important food safety issues, strategies to address them must be innovative, based on sound science, and effectively coordinated with the Agency's federal partners, including USDA, CDC and EPA, and the states.

FDA's goal is to reduce foodborne illnesses by expanding the use of preventive control systems; expanding compliance monitoring of domestic and imported products; increasing the public's understanding and use of safe food handling practices; and developing more effective techniques for detecting, preventing and controlling foodborne hazards.

FDA – International Harmonization of Standards. FDA, other government regulatory bodies, and industry participate in international harmonization activities to help reduce the regulatory burden on industry and to bring products to the market more quickly. Acceptance and use of international safety standards that satisfy U.S. consumer protection goals will improve product safety and public health, reduce FDA's import inspection burden, and help facilitate the importation and exportation of products. By harmonizing international requirements, the industry hopes to reduce the costs of bringing products to market. FDA will continue to participate in international standard setting activities such as General Agreement on Tariffs and

Trade (GATT), the North American Free Trade Agreement (NAFTA), and the Codex Alimentarius, to promote development and adoption of science-based international standards and ensure FDA's ability to protect the U.S. public health.

FDA – Science and Research Support for Premarket Reviews. FDA's highest priorities include improving its science base and conducting research, especially to support the review of premarket applications. FDA's goals in conducting research are to develop: 1) in-house scientific experts, especially in emerging technologies; 2) scientific guidance for product sponsors and reviewers; and 3) science-based standards. In-house scientific experts consult with product reviewers on product applications. Scientific guidance benefits both applicants and review staff in developing and reviewing applications. FDA Modernization Act requires FDA to recognize and use standards established by national or internationally recognized standard development organizations in the application review process, especially with medical devices. FDA's scientific efforts will allow the Agency to expand its participation in standards development and harmonization. Since data relating to the aspects of safety and/or efficiency covered by the standards will not be required in the premarket application, the review process can be expedited.

CDC – Epidemic Services. Epidemic services cover a vast spectrum of activities: preventing and controlling epidemics and protecting the U.S. population from public health crises including biological and chemical emergencies; developing, operating, and maintaining surveillance systems, analyzing data, and responding to public health problems; training public health epidemiologists; developing leadership and management skills of public health officials at the federal, state, and local levels; carrying out the quarantine program as required by regulations; and publishing the *Morbidity and Mortality Weekly Report*, CDC's main channel for communicating public health news about disease outbreaks and trends in health and health behavior.

Selected FY 2000 Performance Goals and Measures

♦ Enhanced basic foodborne disease surveillance and control activities, including standard molecular subtyping methodologies for bacterial foodborne pathogens that began with *E. coli* 0157:H7, will be expanded to include Salmonella Enteriditis. *CDC Plan*

♦ The proportion of reported foodborne outbreak investigations in which the causative organism or toxin is identified will be maintained at 60%. *CDC Plan*

♦ Increase the frequency of high-risk domestic food establishment inspections to once every one to two years. *FDA Plan*

♦ Develop methods of predicting, more quickly and accurately, the risk associated with foodborne pathogens. *FDA Plan*

♦ Improve inspection coverage by inspecting 36 percent of registered human drug manufacturers, repackers, relabelers and medical gas repackers. 26% of establishments were inspected in FY 1998. *FDA Plan*

- Meet the statutory biennial inspection requirement by inspecting 50 percent of registered animal drug and feed establishments. 34% of establishments inspected were inspected in FY 1998. *FDA Plan*

- Ensure that at least 97 percent of mammography facilities meet inspection standards, with less than 3 percent of facilities with Level 1 (serious) inspection problems. FY 1997: Less than 3% with Level 1 findings. *FDA Plan*

- Epidemic Intelligence Service (EIS) officers will respond to at least 95% of the requests for epidemic assistance from domestic and international partners. *CDC Plan*

- Eighty percent of the domestic seafood industry will be operating preventive controls for safety as evidenced by functioning Hazard Analysis Critical Control Point (HACCP) systems. *FDA Plan*

- Improve inspection coverage for both domestic and foreign medical device manufacturers to 23 percent in FY 2000 (32 percent for domestic manufacturers and 12 percent for foreign manufacturers); improve inspection coverage for class 2 and class 3 only domestic and foreign medical device manufacturers to 45 percent in FY 2000 (49 percent for domestic manufacturers and 35 percent for foreign manufacturers); and implement the mutual recognition agreement (MRA) with the European Union (EU) for foreign inspections. *FDA Plan*

Programs Supporting This Objective

FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
National Center for Toxicological Research

CDC
Infectious Diseases
Epidemic Services

HCFA
Medicare
Medicaid

Research

HHS Goal 6: STRENGTHEN THE NATION'S HEALTH SCIENCES RESEARCH ENTERPRISE AND ENHANCE ITS PRODUCTIVITY

From the HHS Strategic Plan, September 1997. Improvements in health are grounded on knowledge acquired through research conducted and sponsored by the Department of Health and Human Services (HHS) and other entities, both public and private. In the scope and quality of the science it sponsors, HHS sets the pace for the world in medical, epidemiological, behavioral, and health services research. It does so through strong, sustained public support for health sciences research.

The National Institutes of Health (NIH) plays a vital role in the nation's medical research enterprise. NIH-sponsored research generates knowledge that leads to improvements in the health and quality of life of the American public. It also provides a continually expanding knowledge base for the development of commercial products by the pharmaceutical, medical device, and biotechnology industries and by other key components of the national medical research infrastructure. Through its support of research training, the NIH provides the nation with highly trained scientists who rise to leadership in publicly funded research activities and in the biotechnology and related industries. To a significant degree, future improvements in the health of the American people depend upon sustaining both the research infrastructure that has been developed through NIH support and the basic principles that have enabled NIH research investments to be highly productive.

The Centers for Disease Control and Prevention (CDC) also conducts a strong program of epidemiological and population-based research to protect the public health and prevent and control disease, injury, and disability.

Finally, the Department's health services research plays a critical role by identifying what is most effective and cost-effective in day-to-day practice in community settings and by identifying the most efficient approaches for delivering and financing those services. Expansion in research investments across a broad front of scientific disciplines and operating divisions within the Department will do more than anything else to ensure improvements in health status and in the kinds and quality of services sponsored by the Department.

The Department also enhances the productivity of the nation's research enterprise through such means as international scientific cooperation and regulatory policies that encourage investments in research by the private sector.

Four principles are central to the Department's research investment strategy:

Basic Research. First is the high priority accorded to basic research in the life sciences and fundamental methodological work in health services research. In the area of life sciences, one need look no farther than the history of the biotechnology industry to see the wisdom of this approach. HHS investments in basic research undergird epidemiological, clinical, and health services

research. In the case of the last, they have laid a foundation for better administration and reimbursement in both the public and the private sectors.

Investigator-Initiated Research. The second principle is the high priority accorded to sponsorship of investigator-initiated research. The Department traditionally has eschewed top-down direction for science and instead has relied primarily on individual scientists to propose and carry out specific research projects within the context of broad program goals and policy priorities enunciated by its agencies. As a result, HHS has been uniquely effective in harnessing the creative energies of scientists throughout the nation toward improving human health and well-being.

Peer Review. Third is the reliance upon peer review to assess the quality of research proposals and outcomes. Determining the relative technical merits of competing research ideas is one of the most difficult tasks facing any research agency. The Department's success year after year in directing investments to the most promising scientific opportunities and the most capable investigators stems largely from its commitment to seeking and heeding the advice of leading experts drawn from the pertinent scientific communities.

Research Capacity/Infrastructure. Fourth is the Department's commitment to sponsoring research in a wide variety of institutional settings and to encouraging a healthy research enterprise in the for-profit sector. Universities, not-for-profit research organizations, hospitals and other practice settings, small and large businesses, and government laboratories—each in its own way has provided a hospitable environment for important scientific initiatives. Also, in view of the unique role played by academic institutions, the Department will continue its efforts to help research-intensive universities remain strong. In particular, it will maintain its policy of paying a fair share of research costs and will collaborate with academic health centers to find ways to counter the destabilizing effects of managed care upon clinical research and the education of health professionals. Finally, the Department will enhance the base of highly qualified scientific investigators.

The Department reaffirms these principles as the core of its strategy to guide new investments to increase the nation's knowledge base about health science and maintain its quality. HHS intends to apply them even more broadly in the years immediately ahead.

HHS 6.1: Improve the Understanding of Normal and Abnormal Biological Processes and Behaviors

From the HHS Strategic Plan, September 1997. Advancing the understanding of fundamental life processes is essential for progress in improving health and combating disease and disability. New knowledge of the biological and behavioral processes that operate throughout the lifespan affords the most powerful means for understanding the course of disease and how it can be delayed, treated, cured, or ultimately prevented.

Basic science studies matter at all levels of aggregation, from the materials we experience every day down to their most fundamental constituents. This progress leads to new scientific and technical knowledge and, years later, to innovative products and commercial profits. These advances have generated millions of high-skill, high-wage jobs and significantly improved the quality of life for Americans.

The link between medical research and improving health is well illustrated by the vast new knowledge on the characteristics of various human genes that is accumulating almost daily. This research is providing many new concepts and tools for understanding the molecular mechanisms of various kinds of cancer and other chronic diseases; it is also opening the way to new avenues for prevention and therapy.

Key FY 2000 Activities, Initiatives, and Strategies

Administration Initiative – Supporting Research. This initiative continues HHS' wise investments in biomedical science and health care quality research. The National Institutes for Health (NIH) spearheads worldwide efforts to advance health through medical science. HHS requests $15.9 billion for NIH, an increase of $320 million. At this level, NIH would fund nearly 30,000 extramural research projects. Moreover, the FY 2000 budget proposes a program level increase of $35 million, or 20 percent, over FY 1999 for the Agency for Health Care Policy and Research (AHCPR). Their efforts (see Objective 6.4) include bridging the gap between science and health care, and research to improve cost-effectiveness and quality of care, especially among the diseases that affect Medicare and Medicaid costs the most.

Lastly, the Administration again proposes a three year demonstration to encourage higher participation for Medicare beneficiaries in NIH sponsored cancer clinical trials. Only three percent of cancer patients participate in clinical trials; many scientists believe that greater participation in these trials could improve results.

NIH – Much of health care today still involves treating the symptoms of disease without understanding its underlying causes and the precise mechanisms by which disease develops (pathogenesis). In order to effectively and systematically attack the diseases of today such as cancer, heart disease, AIDS, arthritis, diabetes, and addiction, we need a broad base of knowledge about living systems. We need to understand how living systems operate at both a "micro" level–the structure and function of proteins, nucleic acids (DNA and RNA),

carbohydrates, and fats–as well as at more "macro" levels–how these molecules organize and function together as living units, i.e., cells, tissues, organs, whole organisms, and even communities. As important, we need to understand how disease, genetic alterations, and environmental factors affect the function of these molecules, cells, tissues, organs, and organisms, and their consequences for human health.

Fortunately, all organisms are made of the same basic materials, and many share similar genetics and physiologic processes, so researchers seeking to understand both normal and disease processes in humans can learn a great deal by studying similar systems in simpler "model organisms" like bacteria, slime molds, yeast, fruit flies, zebrafish, and rodents. Model systems have proven essential tools for understanding a wide array of human conditions, providing critical new insights into mechanisms associated with cardiovascular, gastrointestinal, neurological, structural, and other defects that may have counterparts in human disorders. Animal models can be used for studying the physiological course of a disease, determining the identity and function of the genes and proteins involved in health and human disease, testing new treatments, and developing and testing methods for preventing disease and disability.

At first glance, this goal may appear to focus on laboratory research, but it actually encompasses clinical research as well. The aim is, of course, to be able to put all the parts together to understand normal biological activities and how they malfunction in disease and disability. This, in turn, will provide the fundamental theories and concepts for more disease-oriented investigations that lead to new methods for diagnosing, treating, and preventing disease and disability. It may take years, however, after a new discovery is made for the potential health applications to become clear. Thus, just as no one can predict what researchers will discover in the future, neither can the eventual clinical applications of today's results be known. As productive as the past has been, the future promises to be still more exciting as researchers gain an even greater understanding of living systems and apply that understanding to questions of health and disease.

NIH – The rapid progress of the Human Genome Project, a growing understanding of the genomes of other species, and new methods for the manipulation of genes are swiftly changing concepts of disease and strategies for its control. The Human Genome Project seeks to understand the genetic instructions that make each of us unique, influencing not only what we look like, but what diseases we may eventually develop. The goal is to find the locations of the 100,000 or so human genes and to decipher their genetic sequences. Once a gene has been discovered, researchers can then begin to learn how the gene normally functions in the body and how an altered form of the gene may affect health or contribute to the development of disease. Steady progress is already ushering in an era of molecular medicine, with the promise of precise new approaches to the diagnosis, treatment, and prevention of diseases.

The basic building block of DNA is the nucleotide, and DNA consists of a string of the nucleotides adenine, cytosine, guanine and thymine (A,C,T,G). Human genes may exist in many different forms, some of them differing only by a single A,C,T, or G. When such minor variations, known as polymorphisms, occur in regions that instruct the production of a specific protein, an abnormal protein may be formed which may lead to a change in the normal functioning of the human body and which may manifest itself as disease. Additional research

efforts will focus on determining the location and function of these genetic variations, with the goal of correlating specific polymorphisms with clinical disease manifestations. Such information would be invaluable to medical research and practice—allowing the identification of those at risk for disease, and contributing to the development of new treatments and preventive strategies for specific populations.

Genetic medicine is built on the analysis of genomes (the complete repertoire of genes) present not only in human beings, but also in other model animals, and microbes. By understanding the genomic sequence of other organisms, we will be able to understand more fully organisms that cause human disease, such as e-coli, and at more rapid pace, the implications of mutations in the human genome. The construction of genetic and physical maps of these genomes, determination of the sequences of all of their component genes, examination of the properties and functions of the proteins made by each gene, and an understanding of the contributions normal and mutant genes make to disease will completely change the way medicine is practiced.

In recent years, many genes involved in hereditary diseases have been identified. The ability to isolate and copy these genes allows biologists to study what goes wrong in cells to cause disease. Scientists are working on many techniques to correct faulty genes, including ways to "sneak" new nucleotide sequences past the body's defense mechanisms. The goal, once the sequences are taken up by a cell, is to get them integrated in such a way that the desired substances are properly made–in other words, gene therapy. Gene therapy is also beginning to be employed in new and creative experiments that may someday lead to new ways of treating many different disorders. In the future, it may be possible to use it to genetically engineer living cells to make their own "medicines" in response to carefully controlled chemical signals from outside the cell.

Selected FY 2000 Performance Goals and Measures

- **Add to the body of knowledge about normal and abnormal biological functions.** Demonstrated progress in advancing scientific understanding in key fields bearing on our knowledge of biological functions in their normal and abnormal states. Data will be reported on the new findings and theories forthcoming from the various research projects the NIH conducts and supports. *NIH Plan*

- **Develop critical genomic resources, including the DNA sequences of the human genome and the genomes of important model organisms and disease-causing microorganisms.** Demonstrated increases in the pace and progress of genome sequencing – U.S. annual production rate of human genomic sequence to reach 190 million base-pairs in FY 2000. (The current long range plan for 1998-2003 calls for the worldwide production rate to reach 500 million base-pairs of finished sequence annually by FY 2003. Under this plan, one-third of the human genome will be sequenced by the end of 2001 and the sequencing completed by the end of 2003.) Other assessment measures include the number of sequence records added to GenBank, the number of GenBank searches, development of genomic libraries of the rat, completion of genome sequences of infectious pathogens, and progress in sequencing full-length human cDNAs. *NIH Plan*

Programs Supporting This Objective

NIH
Research

HHS 6.2: Improve the Prevention, Diagnosis, and Treatment of Disease and Disability

From the HHS Strategic Plan, September 1997. Medical research is yielding knowledge that can be translated into new and improved methods for detecting, diagnosing, and treating disease. New insights into normal disease processes will also provide the knowledge for developing preventive measures, which are the ultimate manifestation of improvements in health.

The importance of this research is summed up by a 1996 National Science and Technology Council report, *Technology in the National Interest*. The report recognizes the contributions of medical research when it states, medical research supported by the National Institutes of Health has led to many discoveries that have improved both the health and quality of life of the American people. This is the NIH's foremost goal, but medical research also yields technological and economic benefits."

In addition, research at CDC is contributing to the understanding of pathogens and immunology and the basis for the prevention of the transmission of diseases.

Key FY 2000 Activities, Initiatives, and Strategies

CDC – The applied techniques of epidemiology, laboratory, behavioral, and social sciences are the primary tools that CDC uses to understand the causes of poor health, identify populations at risk, and develop interventions for disease control and prevention. As research provides more information about the relationships between the physical, mental, and social dimensions of well-being, a broader approach to public health has become important in the quest for answers to prevent and solve health problems. CDC is committed to expanding its research agenda to help bridge the gap between research and public health practice. Through the integration and communication of scientific information, the most effective public health solutions will be translated into practice in the Nation's communities.

CDC's strategy for assuring a strong science base for public health action requires an agency commitment to support and conduct high quality epidemiologic, laboratory, behavior, and social science research. Through its programs in Environmental Health, Infectious Diseases, Occupational Safety and Health, Epidemic Services, and the Prevention Centers, CDC advances the science base in public health by conducting and supporting both extramural and intramural research on a wide range of public health issues. For FY 2000, research on several major public health issues will be conducted in order to improve decision making, to examine health outcomes, or to prevent disease.

NIH – New methods and improved approaches for preventing or delaying the onset or progression of disease and disability are being developed through research. Disease and disability exact enormous tolls on our society, both economic and personal. Rising health care costs highlight the importance of research that seeks to prevent disease and disability, or to delay and/or minimize its impact. In the quest for effective and efficient means of disease

prevention, knowledge about basic mechanisms of illness and health must be complemented by public education programs aimed at health-promoting lifestyles and practices.

The development of preventive, delaying, or disease-halting strategies requires a multi-disciplinary approach. Epidemiologic studies provide a necessary foundation for any disease prevention program by identifying the magnitude, and possibly the variability, of a disease within any given population. The epidemiologic patterns of targeted diseases may identify subpopulations that are at risk for developing specific diseases, as well as provide information about the course of disease development in different environments and in different age, ethnic and socioeconomic groups. Prevention and disease-halting strategies also require a solid understanding of disease mechanisms. For example, it is important to know what causes the disease, how the disease affects specific cells or organs, if there is a genetic basis or predisposition for developing the disease, and whether a person's immune system plays a role in the disease process. A solid understanding of the disease mechanism facilitates the development of effective ways to prevent or delay the disease. Evaluating any new therapies or behavioral approaches requires clinical research and often clinical trials. Behavioral studies are also needed. Effective strategies for prevention or control of a disease may include a new medication, or an alteration in behavior or life-style. Strategies are needed to both educate the public as well as encourage the public to take advantage of these findings.

Targeting preventive and disease- or disability-delaying health interventions to at-risk individuals, as opposed to the general population, permits efficient use of health care dollars, a consideration that will assume increasing importance as baby boomers age and as the ability to identify at-risk populations increases. Researchers understandably are assigning high priority to studies that will identify risk factors for disability, predict disabling events, sharpen screening processes to identify target populations, and design and evaluate interventions specifically for individuals at risk for disability and disease.

NIH – Research is paving the way to improve current and, develop new, methods for diagnosing disease and disability. Early diagnosis and detection of disease is often a key requisite for effective treatment and prevention of disease and disability. Some of the most life-threatening diseases and disabilities can only be controlled or cured if they are diagnosed and treated in the earliest stages. Diagnostic methods include a broad array of biomedical technology, e.g., machines that directly visualize the body, cells, and tissues; instruments that can measure specific body functions; and tests that detect minute quantities of biological and inorganic materials. Despite the extreme variability, diagnostic tools must be accurate and safe. It is also advantageous if they are inexpensive, noninvasive, easy to use and pain-free.

Research to create new diagnostic tools is closely intertwined with basic disease research; diagnostic tools are most commonly developed after the mechanisms of the specific disease process are understood. Studying the efficacy and accuracy of diagnostic tools requires clinical research as well as health services research. It must be shown that a given test is both reliable and effective.

NIH – Research is also paving the way to improve current and, develop new, methods for treating disease and disability. The aim of much of NIH research is the development of new

and improved therapeutics. This pathway to our ultimate goal of better health requires a strong foundation of understanding disease mechanisms and normal and abnormal biological functions. Searches for new therapies depend on advances in chemistry, bioengineering, enzymology, structural biology, genetics, immunology, cellular and molecular biology, and pharmacology.

New techniques to rapidly screen chemical compounds are now greatly expanding the pool from which possible therapeutic substances can be drawn. The study of molecular structures by x-ray crystallography has yielded detailed understanding of many molecules critical to health, as well as therapeutic molecules specifically tailored to "fit" the structures and thus alter their chemical activity. In addition, the science of synthetic chemistry has yielded many improved ways to design new therapeutic substances.

Clinical research is the final common pathway to the development of new therapeutics. New approaches, be they drugs, devices or changes in behavior, must ultimately be evaluated in humans. This usually requires clinical trials. In addition, health services research is needed to study the ultimate effect of any new approach on the burden of a disease, both to the individual and to society.

NIH – In support of the President's goal of developing an AIDS vaccine, NIH is supporting vaccine research on the prevention of AIDS. A vaccine works by sensitizing the body's immune system to a particular disease-causing bacteria, virus, toxin, or a component of a pathogenic organism. When the infectious agent subsequently invades the body, the immune system recognizes it and mounts an immediate and robust response to destroy the invader before it can cause disease. The many successes of traditional vaccines are well known, but other serious and fatal diseases still have proven stubbornly resistant to vaccines, demanding new approaches.

A safe and effective AIDS vaccine is a global public health imperative. More than 29 million people are infected with HIV, with more than 3 million of these infections occurring in the past year. Without an effective vaccine, AIDS will soon surpass tuberculosis, malaria, and measles as the leading infectious cause of death worldwide. The NIH is developing an intramural Vaccine Research Center (VRC) to focus on AIDS vaccines. When President Clinton announced the initiation of the VRC in May 1997, he also challenged the NIH and the scientific community to produce an AIDS vaccine within the next 10 years. As part of the effort to meet this challenge, the VRC will be a joint venture between two NIH components—the National Cancer Institute and the National Institute of Allergy and Infectious Diseases. The primary focus for the VRC will be to stimulate multi disciplinary research, from basic and clinical immunology and virology through to vaccine design and production. Initially, the VRC will be a "laboratory without walls," including established intramural labs focused on this area of research. Later, as scientists are recruited from the extramural community, the NIH will consider constructing a building on the campus to house the VRC.

AHCPR – To test the effectiveness of health care improvement approaches, AHCPR will: 1) study the implementation of evidence-based information in diverse health care settings to determine effective strategies for enhancing practitioner behavior change and improving patient

behavior, knowledge and satisfaction; 2) identify the factors which determine the success of quality improvement strategies and to what extent these vary by the nature of the problem addressed and the target population; 3) test innovative approaches to teaching evidence-based practice to health professionals, including physicians, nurses and dentists; 4) improve the quality of care during transitions between health care settings, including primary care, acute hospital care and long-term care settings, and between specialists to improve integration and to build on the agency's 1997 initiative to study care at the interface of primary and specialty care; and 5) promote the use of shared decision-making in clinical practice and evaluate its impact on quality, costs, and satisfaction.

AHCPR – Research on Priority Health Issues. The key features of this priority include: 1) explicit identification of conditions, populations, and problems that reflect national priorities, 2) a commitment of sufficient funds to each area to yield substantial advancements in 3 to 5 years, 3) a coordinated strategy to link researchers with the future or intended users of the findings from the outset, and 4) close linkage between researchers and important implementation opportunities in the health care system to maximize rapid adoption of the research findings. The areas to be studied in this priority are: Improving health outcomes and health care research on vulnerable populations; assessing the outcomes, effectiveness, and cost-effectiveness of clinical treatment programs for domestic violence against women; cross-cutting research in clinical preventive services; pharmaceuticals research, including the CERTS program; the effects of competition and value-based purchasing on health care markets; and evaluating the impact of managed care.

CDC – Breast and Cervical Cancer. CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides cancer screening for under-served women, particularly low-income women, older women, and members of racial/ethnic minorities. Almost all deaths from cervical cancer and an estimated 30 percent of deaths from breast cancer in women over age 50 are preventable though widespread use of Papanicolaou (Pap) testing and screening mammography. CDC's NBCCEDP created the foundation for an aggressive response to breast and cervical cancer and ensures the delivery of successful screening services. CDC supports activities at the state and national levels in the areas of screening referral and follow-up services, quality assurance, public and provider education, surveillance, collaboration, and partnership development.

CDC – Epidemic Services. CDC publishes the *Morbidity and Mortality Weekly Report* (MMWR), considered to be the agency's main communication mode for disease outbreaks and trends in health and health behavior. The MMWR is disseminated to more than 700,000 people who work in the public health and is available electronically to private physicians, hospitals, and other health care professionals.

CDC – Infectious Diseases. The challenges posed by new and resurgent infectious disease threats will be addressed within the CDC's Infectious Disease Program. Major program efforts include enhanced disease and laboratory-based surveillance systems, improved laboratory capacity to detect, control and prevent infectious diseases domestically and internationally.

- CDC – Environmental Health. The current inability to effectively measure toxic substances in humans limits our ability to deal effectively with environmental emergencies and compromises the results of studies that are looking for causes of environmental diseases. CDC's environmental health program will expand its ability to measure toxic substances in humans. The availability of assessment methods will enable the nation to effectively implement and evaluate environmental disease prevention programs and measure trends in exposure of the U.S. population to toxic substances.

- HCFA – The Balanced Budget Act of 1997 provides for additional coverage for preventative services (tests and screening), such as prostate cancer screening for men over age 50, screening pap smear and pelvic exams, colorectal cancer screening, diabetes self-management, bone mass measurements, and vaccines outreach expansion (influenza and pneumococcal vaccination).

- FDA – Scientific Research. FDA's research provides the basis for FDA to evaluate product safety, estimate human risk, and make sound science-based regulatory decisions; and to promote the health of the American people through enforcement and compliance. The FDA has expedited drug, device and biological approval procedures to provided needed disease diagnostic tests and therapies to consumers more quickly. Research results that improve the ability of FDA reviewers to evaluate and predict rapidly and accurately the adverse effects FDA-regulated products may have on humans, that evaluate new technologies and that revise existing technologies to meet new regulatory challenges are vital to carrying out the Agency's consumer protection mission. Some of the specific aims of FDA's research are to understand the critical biological events that cause some FDA-regulated products to elicit a toxic reaction in humans; to develop methods to better assess human exposure, susceptibility and risk to toxic agents; and to apply these scientific findings to FDA's premarket application review and product safety assurance efforts.

  One of FDA's new strategies for predicting product toxicity includes using new test systems that are based on understanding a product's mode of action, refining new and existing tests, as well as conducting studies that help reduce the uncertainty of extrapolating laboratory data to humans. A second strategy focuses on developing computer-based predictive systems that include an accumulation of scientific data and allow a reviewer to predict the toxicity of a drug or chemical in humans and animals based on the drug or chemical's structure and/or activity. This type of system may reduce approval time for estrogen-mimicking drugs used for breast cancer treatment or hormone replacement therapy. Some of FDA's research will also focus on providing data not available from manufacturers in the scientific literature on specific agents, such as anti-estrogens, neurotoxins, food contaminants, and aquaculture therapies. Other Agency research will focus on developing and applying new toxicologic and analytical test methods for more rapid, yet sensitive detection of bacterial pathogens and toxins in food and drugs and decomposition in seafood.

- FDA – Interagency Collaboration. Encouraging interagency cooperation allows the substantial expertise of other government scientists to focus their efforts on similar problems. For example, working with other agencies allows the FDA to prevent illness and epidemics. The agency collaborates with the National Institutes of Health to speed drug and vaccine development so that these products can reach consumers more quickly. This inter-agency

cooperation also allows the Agency to determine the modes of infection and educate scientists that could lead to new testing methods.

OPHS – OPHS supports several research and service demonstration grant programs and program evaluations to identify what works, model strategies and approaches, and best practices that address the barriers and health problems of racial and ethnic minorities and identify effective disease and disability prevention and public health approaches. Two major grant programs which will continue to be administered by OPHS are the Bilingual/Bicultural Service Demonstration Grants Program to improve access to health care by reducing cultural and linguistic barriers, and the Minority Community Health Coalition Demonstration Grants Program to address reduction of racial disparities in targeted health areas.

OPHS – The Adolescent Family Life (AFL) program supports demonstration projects to develop models aimed at (1) promoting abstinence from sexual intercourse as a means of preventing adolescent pregnancy and sexually transmitted diseases, including HIV, and (2) assisting pregnant and parenting adolescents, their children and their families. The program also funds research projects examining the causes and consequences of adolescent premarital relations, adolescent pregnancy and adolescent parenting.

Selected FY 2000 Performance Goals and Measures

♦ **Develop new and improved approaches for preventing or delaying onset or progression of disease and disability.** Demonstrated progress in developing (or facilitating the private sector's development of) new or improved approaches (e.g., vaccines and behavioral strategies) for preventing or delaying the onset of diseases and disabilities -- and which reflect NIH responsiveness to emerging health needs, scientific opportunities, and new technologies. Data will be reported on the new concepts and capabilities forthcoming from across the various research projects the NIH conducts and supports. *NIH Plan*

♦ **Develop new and improved methods for diagnosing disease and disability.** Demonstrated progress in developing (or facilitating the private sector's development of) new or improved diagnostic methods (e.g., imaging devices) that are more accurate, less invasive, and/or more cost-effective -- and which reflect NIH responsiveness to emerging health needs, scientific opportunities, and new technologies. Data will be reported on the new concepts and technologies forthcoming from across the various research projects the NIH conducts and supports. *NIH Plan*

♦ **Work towards the President's goal of developing an AIDS vaccine by 2007.** Demonstrated accomplishments in areas including increases in the research portfolio supporting innovative vaccine discovery, increased interactions between academic investigators and industry to enhance opportunities for vaccine discovery and product development, and completion of ongoing trials and initiation of additional trials of new vaccine concepts and designs. *NIH Plan*

♦ Reduce the prevalence of chronic and disabling conditions and improve quality of life for those already affected by these conditions by building nationwide programs in chronic disease

prevention and health promotion, and intervening in selected diseases and risk factors. FY 2000 measures:

- 100% of CDC-funded state diabetes control programs will adopt, promote and implement patient care guidelines for improving the quality of care received by persons with diabetes. Baseline: FY 2000: 60% (1998)

- For all states that receive CDC-funding for comprehensive diabetes control programs, increase by 10% the percentage of diabetics who receive an annual eye exam and annual foot exam. Baseline: Eye 62%, Foot 52% (1996) *CDC Plan*

♦ Reduce morbidity and mortality attributable to behavioral risk factors by building nationwide programs in chronic disease prevention and health promotion and intervening in selected diseases and risk factors. Sample FY 2000 measure: Stop the increase in smoking among young people. Baseline: 36.4% for 9 - 12 graders (1997) *CDC Plan*

♦ Develop and strengthen epidemiologic and laboratory methods for detecting, controlling, and preventing infectious diseases. Sample FY 2000 measure: Assays to detect HIV mutations that are resistant to commonly used therapeutic agents will be developed and optimized. *CDC Plan*

♦ Strengthen domestic and global epidemiologic and laboratory capacity for surveillance and response to infectious disease threats. Sample FY 2000 measure: Enhanced surveillance for influenza will be initiated in 60 state and local health departments. Baseline: 0 enhanced surveillance for influenza (1998). *CDC Plan*

♦ Increase by 25% the number of toxic substances that can be measured by CDC's environmental health laboratory by the year 2002 from a baseline of 200 in 1997, so state-of-art laboratory methods can be employed to prevent avoidable environmental disease. FY 2000 measure: human exposure to 20 additional toxic substances will be measured (inclusive of the 8 in FY 1999). *CDC Plan*

♦ Increase early detection of breast and cervical cancer by building nationwide programs in breast and cervical cancer prevention. FY 2000 measures:

- At least 67% of women in the NBCCEDP aged 50 and older with breast cancer will be diagnosed at localized stage or stage 0/1. Baseline: 64% (1995)

- The rate of invasive cervical cancer diagnosed in women aged 50 and older screened by the NBCCEDP is no more than 40 per 100,000 Pap tests provided. Baseline: 41 per 100,000 (1996) *CDC Plan*

♦ Develop modeling techniques to assess human exposure and dose response to certain foodborne pathogens. *FDA Plan*

- Develop a new biological assay to measure genetic change and validate two existing models that predict human genetic damage. *FDA Plan*

- Conduct molecular epidemiology studies to identify biomarkers of the most frequently occurring cancers in highly susceptible subpopulations. *FDA Plan*

- Develop partnerships with government, industry, and academic scientists to conduct studies that demonstrate cross-species comparability and eliminate assumptions necessary for extrapolating laboratory toxicity data to human disease. *FDA Plan*

Programs Supporting This Objective

AHCPR
Research on Health Costs, Quality, and Outcomes
CDC
Breast and Cervical Cancer Prevention Research
Epidemic Services
Prevention Centers
Infectious Diseases
Environmental Disease Prevention
Sexually Transmitted Disease
Occupational Safety and Health

FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
National Center for Toxicological Research
Tobacco
NIH
Research
OPHS

HHS 6.3: Improve the Public Health Prevention Efforts Through Population-Based Research

From the HHS Strategic Plan, September 1997. Research addressed to controlling the spread of communicable diseases, eliminating the environmental causes of illnesses, and promoting health behaviors that forestall illness and premature death also is essential to HHS's efforts to improve the health and quality of life of the nation's citizens. Within the Department, the CDC is the focal point for population-based, public health research. This research is used by the Department and public health agencies throughout the nation to solve public health problems and improve the effectiveness of prevention programs. For example, research on the prevention of sexually transmitted diseases and childhood lead-poisoning, translated into public health practice, has significantly advanced the control of those diseases.

Key FY 2000 Activities, Initiatives, and Strategies

- CDC – Prevention Research. Through applied research, CDC identifies emerging problems, tests solutions, and determines how to translate into practice the knowledge that has emerged from biomedical research. Working with public and private sector research partners, CDC strengthens its ability to rapidly respond to complex public health problems facing communities. CDC's prevention research program can be characterized as problem-solving, population-based research which focuses on preventable risk factors using multidisciplinary, community-based approaches. This type of public health research engages teams of scientists (e.g., epidemiologists, laboratorians, economists, and behavioral scientists) working in cooperation to apply scientific methods to develop and evaluate public health strategies and interventions. Increasingly, CDC is working with extramural researchers as a part of the team to address the complexity of many public health problems.

- CDC – Environmental Disease Prevention. CDC examines health outcomes that result from interactions between people's unique biologic, social, and lifestyle factors and their physical, chemical, and developmental environment. CDC's environmental health sciences laboratory develops tests of human exposure to toxicants (biomonitoring); and, when combined with epidemiologic studies, these tests provide vital information about how exposures contribute to serious human disease. In addition to gathering and analyzing human data on environmental exposures and disease, CDC leads efforts to translate scientific data into practical and cost-effective public health actions. This work by the National Center for Environmental Health complements that of the National Institute for Occupational Safety and Health (NIOSH) at CDC, which conducts research and provides national and world leadership in preventing work-related illness, death, and disability.

- CDC – Preventing Unnecessary Death and Disability from Chronic Disease Initiative. This initiative will include surveillance and epidemiologic research to detect new trends and better elucidate risk factors and their relationships with chronic diseases; applied behavioral, genetic, and occupational research to test new prevention strategies; implementation of comprehensive

statewide prevention programs; and national leadership and coordination to mobilize public- and private-sector resources.

- CDC – Heart Disease and Health Promotion. CDC will conduct cardiovascular disease prevention research to target disadvantaged populations, plan interventions in a variety of settings, and modify policies and the environment for new emerging risk factors, (e.g. homocysteine, antioxidants, genetic factors); secondary prevention of cardiovascular disease (e.g., physician practices, medical records, laboratory, and hospital discharge data; and physical activity and nutrition. In support of its efforts to prevent tobacco use, CDC will conduct prevention research and research on the health effects of tobacco additives and smoke constituents.

- CDC – Injury Prevention and Control (IPC). IPC is designed to prevent premature death and disability and reduce human suffering and medical costs caused by injuries. IPC accomplishes its mission through: extramural and intramural research, developing, evaluation, and implementing prevention programs, assisting State and local health jurisdictions in their efforts to reduce injuries, and conducting prevention activities in partnership with other Federal and private-sector agencies. Evaluation of intervention programs is a key component of CDC's overall strategy to discover what works and determine how to deliver programs to the American people.

- IHS – Treatment and Prevention. The IHS continues to assist its partners in developing new strategies to prevent communicable diseases through collaboration with the CDC in vaccine research. The IHS also collaborates with CDC and NIH in efforts to prevent and control diabetes in the American Indian and Alaska Native population.

- OPHS – OPHS supports several research and service demonstration grant programs and program evaluations to identify what works, model strategies and approaches, and best practices that address the barriers and health problems of racial and ethnic minorities and identify effective disease and disability prevention and public health approaches. Two major grant programs which will continue to be administered by OPHS are the Bilingual/ Bicultural Service Demonstration Grants Program to improve access to health care by reducing cultural and linguistic barriers, and the Minority Community Health Coalition Demonstration Grants Program to address reduction of racial disparities in targeted health areas.

- OPHS – The national Title X family planning program provides family planning and related gynecological health care services to over 4.5 million individuals each year to assist them in planning the timing and spacing of their children. The program also supports three additional functions: (1) training for family planning clinic personnel, (2) information dissemination and community-based education and outreach activities, and (3) research to improve the delivery of family planning services.

- program supports demonstration projects to develop models aimed at (1) promoting abstinence from sexual intercourse as a means of preventing adolescent pregnancy and sexually transmitted diseases, including HIV, and (2) assisting pregnant and parenting adolescents, their children and their families. The program also funds research projects examining the

causes and consequences of adolescent premarital relations, adolescent pregnancy and adolescent parenting.

Selected FY 2000 Performance Goals and Measures

- Develop and implement a comprehensive plan to guide CDC extramural research activities in the years 2000 – 2004. *CDC Plan*

- Conduct annual assessments of research gaps and needs, including those identified by public health officials, consumers and biomedical researchers. *CDC Plan*

- An annual review of extramural research resources and needs will be conducted. CDC will assess and respond to problems which may be critical to advancing extramural research (e.g., lack of intramural laboratory support, delays in approval of protocols, etc.). This will identify areas which need strengthening to support existing and future extramural research activities. *CDC Plan*

- To strengthen the scope and nature of extramural public health research programs, CDC will conduct periodic assessments of extramural public health research programs that increase the number of young investigator and public health research training opportunities in schools of public health and other programs of public health training; increase the number and scope of training programs for specialties critical to advancing public health research and development; increase extramural funding opportunities in fields critical to improving and advancing technologies supporting public health research (e.g., information systems, analytic resources, etc.); and expand the scope of pubic health research to bridge gaps between public health practice, public health research, bioethics, and health policy research. *CDC Plan*

- Increase collaboration efforts among research universities and community-based organizations to more effectively implement chronic disease and teen pregnancy prevention research and demonstration projects that focus on new intervention methods and provide results to states and local organizations. FY 2000 measures:

  - The 14 university-based Prevention Research Centers will conduct at least two educational sessions per year for public health practitioners and community leaders, focusing on core disciplines in public health, intervention methods, translation, or evaluation. Baseline: 2 Educational Sessions (FY 1999)

  - At least two interventions will be conducted in each of the thirteen demonstration projects to reduce teen pregnancy in their target community. Interventions will be selected by a needs assessment and field test of the program. In FY 1997, one of the thirteen demonstration projects conducted two interventions. *CDC Plan*

- Conduct a targeted program of research to reduce morbidity, injuries, and mortality among workers in high priority areas and high-risk sectors. FY 2000 measures:

  - Annual increases in funding of other federal agencies will be demonstrated.

- Baseline bibliometric amounts for all NORA areas will be completed. *CDC Plan*

♦ Human exposure to 20 additional toxic substances will be measured (inclusive of the 8 in FY 1999). Baseline: Capability to assay 200 toxic substances (1997). *CDC Plan*

♦ By the end of FY 2000, halt the continued increase of obesity in AI/AN 3rd grade children in at least six pilot intervention sites at FY 1999 rate, through the effective implementation of the intervention developed in FY 1999. *IHS Plan*

Programs Supporting This Objective

CDC
Prevention Research
Diabetes and Other Chronic Diseases
Epidemic Services
Prevention Centers
Infectious Diseases
Environmental Disease Prevention
Occupational Safety and Health
Injury Prevention and Control
HCFA
Medicare
IHS
Treatment and Prevention
OPHS

HHS 6.4: Increase the Understanding of and Response to the Major Issues Related to the Quality, Financing, Cost, and Cost-Effectiveness of Health Care Services

From the HHS Strategic Plan, September 1997. The nation's health care system is undergoing a dramatic transformation as a result of rapid mergers and acquisitions among hospital systems, pharmaceutical firms, health plans, and managed care firms. Health care delivery systems are larger and more complex; cost pressures are forcing innovation in how and where care is provided; and the population is getting older.

Health services research, which examines everyday practice in health care, is needed to assess the effect of current change and innovation on the cost, quality, and effectiveness of health care services. Many important questions need to be answered: Have the changes made a difference in who is getting care, how much care is being provided, or what types of services offered? What is the cost and quality of the care being provided? Which services are most cost-effective? How can research findings on effective treatments move more quickly into the everyday practice of providers? New methods and products for assessing quality of service, patient satisfaction, efficiency, and outcomes are also needed. Health services research is important in providing the analytical foundations for making payment reforms, especially in federal programs such as Medicare.

Key FY 2000 Activities, Initiatives, and Strategies

- Administration Initiative – Supporting Research. This initiative continues HHS' wise investments in biomedical science and health care quality research. The HHS FY 2000 budget proposes a program level increase of $35 million, or 20 percent, over FY 1999 for the Agency for Health Care Policy and Research (AHCPR). Their efforts include bridging the gap between science and health care, and research to improve cost-effectiveness and quality of care, especially among the diseases that affect Medicare and Medicaid costs the most.

- HCFA – HCFA directs over 400 research, demonstration, and evaluation projects, many of which are Congressionally mandated studies. As a beneficiary-centered organization, HCFA examines the impact of Medicare, Medicaid, and other state programs on beneficiaries' health status, access to services, utilization, and out-of-pocket expenditures, and the information needs of beneficiaries, providers, and other partners. HCFA has program responsibilities for Medicare, Medicaid, and other state programs, such as the Health Insurance Portability and Accountability Act of 1996, and the State Children's Health Insurance Program.

  Research efforts also explore areas of potential difficulty, for instance, situations where access to care may be inadequate. In addition, many projects focus on program expenditure issues as they relate to payment, coverage, eligibility, and management alternatives under Medicare and Medicaid. Research projects also develop and assess new methods and approaches that can be applied in the areas of quality of health care, alternative health care delivery systems, innovative financing arrangements, and cost containment strategies. HCFA gathers and analyzes data on

program experience and performs evaluations of various aspects of programs. The behavior and economics of health care providers and the overall health care industry are also topics of HCFA research.

Over the years, HCFA research has contributed directly to program improvements. For example, Medicare's current methods of paying providers, including the prospective payment system for hospitals and the Medicare physician fee schedule, are direct results of HCFA research. The Balanced Budget Act of 1997 contains numerous significant policy changes (including prospective payment systems for skilled nursing facilities and home health agencies and a risk-adjusted payment methodology for Medicare+Choice plans) that are grounded in HCFA research.

HCFA – The Balanced Budget Act (BBA) of 1997 requires the development of a number of prospective payment systems (PPS) in traditional Medicare and a risk adjustment methodology for payments to Medicare+Choice plans. The categories of providers or services that are to be paid on a prospective basis include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation hospital services, and services provided in hospital outpatient departments. HHAs, SNFs, and hospital outpatient services continue to be paid on a cost reimbursement basis. Prospective payment for these services is expected to result in more efficient provision of care, and lower costs to the Medicare program. With regard to payment to Medicare+Choice plans, researchers have found that, because of the relatively better health of Medicare Health Maintenance Organization (HMO) enrollees, the current payment methodology results in costs to the Medicare program that exceed the program costs that would have been incurred if the current HMO population had remained in original (fee-for-service) Medicare. HCFA will implement a risk adjustment methodology that accounts for variations in per capita costs based on health status no later than January 1, 2000.

AHCPR – In the field of health services research, the user of the information plays a critical role. If health services research is to improve the quality of health care, it must provide answers to the questions and issues that represent the barriers to improvement. AHCPR emphasizes open communication with users of its research to ensure that it is addressing important questions. This phase of the cycle of research will continue to be an area of emphasis as the Agency implements the initiatives in the FY 2000 budget to assure that research *begins and ends with the user*.

AHCPR – There are many gaps in knowledge in all areas of health care. New questions emerge as new technologies are developed, the population's demographics change, areas of inquiry previously under-emphasized take on greater importance, and research previously undertaken identifies further areas that need attention. Therefore, AHCPR will continue to focus on creating new knowledge and assessing the findings that result from completed projects. This phase of the cycle of research identifies the opportunities for improvement from which changes in health care can be designed and implemented. AHCPR will continue to focus on developing a portfolio of peer-reviewed extramural and intramural research and will also place particular focus on the FY 2000 initiative, "New Research on Priority Health Issues."

- AHCPR – Pharmaceuticals research. AHCPR will build on its successful pharmaceutical outcomes projects to fund research that is responsive to the current needs of health plans, providers and consumers. These studies will emphasize the quality of prescribing practices, comparative studies of effectiveness and cost-effectiveness, and the reduction of adverse drug events.

- AHCPR – Evaluating the impact of managed care. These projects will constitute a systematic effort, with a mix of short- and longer-term research, to determine the impact of managed care and other changes in the organization of care on health care quality; outcomes; and cost, use and access. Areas of likely emphasis include: the implications of the growing use of sub-acute care and rehabilitation and the impact of management strategies and financial incentives such as limitations on referrals, the use of "carve outs" and disease management, primary care redesign, and new physician incentive systems.

- AHCPR – Monitor quality of care through a strengthened MEPS. AHCPR will increase the capacity of the *Medical Expenditure Panel Survey* (MEPS) to enable the development of a national capacity to monitor the quality of care, particularly for populations of national interest, including the chronically ill, poor, racial/ethnic minorities, and children. Expansion will provide the capacity to: 1) report on the quality of care in America nationally and regionally, and for vulnerable populations; 2) examine quality, cost access, and utilization for people with high-cost illnesses such as hypertension, diabetes and cancer, providing critical data for closing gaps in clinical care as outlined in the President's Race Initiative; and 3) track the national impact of new Federal and State programs, such as the Children's Health Insurance Program, on access and cost of care for children, and compare and evaluate the effectiveness of different strategies to reduce the number of uninsured children and increase access to needed services by those who are covered.

- AHCPR – Redesign of the *Healthcare Cost and Utilization Project* (HCUP). AHCPR will redesign and expand HCUP to provide state and community decision-makers a powerful set of linked databases they can use to monitor the impact of major system changes on access, quality, outcomes and cost in their states and communities, and to compare these against the progress of other states and communities.

- HRSA – Rural Health Policy Development. The Rural Health Research Center Program is the only health services research program dedicated entirely to producing rural policy relevant research. It currently supports five research centers that have over 55 major studies underway dealing with such diverse topics as rural emergency room use by rural elderly residents, the impact of asthma guidelines on the care of rural pediatric Medicaid recipients, developing an improved definition of "rural", the financial dependence of rural hospitals on Medicare outpatient revenues and implications for outpatient payment reform, and the potential impacts on rural health care providers of the Balanced Budget Act of 1997.

- NIH – Research activities are supported across a broad spectrum to increase the understanding of issues related to health care quality, cost and cost-effectiveness. Included are efforts to better understand the effectiveness of care provided in various health care settings, the outcomes of clinical care which involves patients in treatment decisions, and the assessment of

measures designed to evaluate quality-of-life aspects of disease prevention modalities. Other examples include conducting research to examine the characteristics of different health care structures and delivery systems and their impact on health and functioning in old age; the economic aspects of older people's access to and use of health care, and relationship to health; and comparative cross-national analyses of health care needs and services.

SAMHSA - Current knowledge development programs (including Jail Diversion, Effectiveness of Consumer Operated Services, Employment Intervention Demonstration Program, ACCESS, Impact of Managed Care on Vulnerable Populations) include cost of services or cost effectiveness components. Understanding that resource allocation decisions need to have the relative costs in addition to effectiveness, SAMHSA programs have developed detailed approaches for collection of service utilization and program fidelity implementation.

Selected FY 2000 Performance Goals and Measures

♦ Baseline performance assessment to be conducted in FY 1999. During FY 1998 and early FY 1999, HCFA will determine how to adapt existing processes to obtain effective assessments of research outcomes. Consideration will be given how to best structure the self-assessment to dovetail with the existing process of developing the 2-year research plan and budget, which currently involves consultation with all HCFA components regarding their research needs. The process for external review will also be developed, based in part on past experience with the use of advisory panels. By mid-FY 1999, we expect to be ready to conduct a baseline assessment of program effectiveness, describing strengths and weaknesses using target levels of performance. *HCFA Plan*

♦ Develop new Medicare payment systems in fee-for-service and Medicare+Choice as required by statute. FY 2000 measures:

- HHA Prospective Payment System (PPS) implementation - October 2000
- Hospital outpatient department PPS - during FY 2000
- PPS for inpatient rehabilitation hospital services - October 2000
- Development and submittal of Secretarial report to Congress on proposed method of risk adjustment on Medicare+Choice - during FY 1999.
- Most recent encounter data will be used to generate actual payment rates for implementation by January 1, 2000. *HCFA Plan*

♦ Definitive agendas for the 3 basic research goals and the new FY 2000 closing the gap initiatives are documented based on consultations with various groups. Six research agendas will be produced and made available to the public. *AHCPR Plan*

♦ 1) Annual report on science advances in three research goal areas (outcomes; quality; and cost, access and use). 2) At least four major findings in each area that have potential to save significant amounts of money, improve quality, save lives or prevent physical suffering, or change the organization and delivery of health care. 3) For each finding, specific steps in translation and dissemination are identified and initiated. *AHCPR Plan*

Programs Supporting This Objective

AHCPR
Research on Health Costs, Quality, and Outcomes
Medical Expenditure Panel Surveys
HCFA
Medicaid
Medicare
Research and Demonstrations

HRSA
Rural Health Policy Development
NIH
Research Program
SAMHSA
Knowledge Development and Application

HHS 6.5: Accelerate Private-Sector Development of New Drugs, Biologic Therapies, and Medical Technology

From the HHS Strategic Plan, September 1997. One of the critical missions of the Department is to protect the public health. The Department performs this role in a number of ways, including the review and approval of new drugs and medical products developed by private sector research. The review and approval process, managed by the Food and Drug Administration (FDA), ensures the effectiveness and safety of the products being brought to the marketplace.

Recent public debate has questioned the length of time it takes for new health products to be developed and made available to the American public. The Department recognizes the tension between the need for a process adequate to protect health from dangerous or ineffective products and the benefits from moving products expeditiously to the market place. It nevertheless believes that the gains to health from accelerating research and development and marketing are compelling. The Department believes it is important to enhance the benefits to the public health by assisting the medical industry in accelerating the research and development process and in moving health products expeditiously to the marketplace.

Key FY 2000 Activities, Initiatives, and Strategies

- Administration Initiative – Expanding FDA Resources. HHS proposes to expand resources available to the FDA to comply with the Nation's drug, food, and medical device laws and improve the Nation's adverse event reporting system. The budget increases of $15.3 million for injury reporting, $52.2 million for product safety assurance, and $11 million for premarket application review are necessary for FDA to meet its statutory requirements and public expectations. In addition, $15.3 million invests in preventing product related injuries.

- FDA – Premarket Application Review Initiative. The research and development community continues to produce new and often technologically complex health care products. FDA facilitates the availability of these products and is required by the Food, Drug and Cosmetic Act to review new product applications within specific time frames. FDA has dedicated several strategies to help reduce the time required to make important new human drugs, veterinary drugs, blood products, medical devices, vaccines and food additives available to the U.S. public. First, FDA will dedicate additional reviewers to high-priority areas. To use reviewers' time efficiently, FDA has re-engineered to shorten some of its product review processes without sacrificing the quality of the review and the safety of the product. Second, initiatives are underway to reduce the requirements for preapproval of low-risk products and to replace the application review process for these products with a notification process. Third, FDA is encouraging product sponsors to consult the Agency early in the research and development process. Early communication helps product sponsors understand what information is needed by FDA and often leads to a high quality application which can move through the FDA approval process more quickly. And finally, all of FDA's product review centers will continue to improve their application and review tracking systems. Improving these systems should result in faster review times for products, and increased productivity for FDA.

- FDA – Injury Reporting Initiative. An estimated 1.3 million Americans are unintentionally injured each year as a result of medical errors. Surveillance of marketed products plays an essential role in increasing the availability of safe and effective medical products for the consumer. One of FDA's primary objectives is to develop and implement a comprehensive surveillance system that improves the quality of information on adverse events and product defects associated with FDA-regulated products. The overall strategy combines elements of surveillance, problem analysis, education, and problem correction by eliminating the conditions that led to the high-risk situation.

  FDA and the industry cannot learn everything about the safety of a product before it is approved, and Americans have chosen to accept this risk in order to have products approved within a reasonable time frame. The tradeoff is that FDA and industry must continue to assess the safety of certain products after their use becomes widespread. For example, postmarket studies of a medical device may provide additional information about long-term uses or the device's effectiveness in a more diverse population. Data that FDA requested for the premarket review can be requested after the product is approved. Making optimal use of postmarket data may reduce the premarket data requirements for some devices. FDA will continue seek ways to minimize the amount of premarket data requested when postmarket studies can provide the appropriate consumer protection.

- FDA – International Harmonization of Standards. FDA, other government regulatory bodies, and industry participate in international harmonization activities to help reduce the regulatory burden on industry and to bring products to the market more quickly. Acceptance and use of international safety standards that satisfy U.S. consumer protection goals will improve product safety and public health, reduce FDA's import inspection burden, and help facilitate the importation and exportation of products. By harmonizing international requirements, the industry hopes to reduce the costs of bringing products to market. FDA will continue to participate in international standard setting activities such as General Agreement on Tariffs and Trade (GATT), the North American Free Trade Agreement (NAFTA), and the Codex Alimentarius, to promote development and adoption of science-based international standards and ensure FDA's ability to protect the U.S. public health.

- FDA – Science and Research Support for Premarket Reviews. FDA's highest priorities include improving its science base and conducting research, especially to support the review of premarket applications. FDA's goals in conducting research are to develop: 1) in-house scientific experts, especially in emerging technologies; 2) scientific guidance for product sponsors and reviewers; and 3) science-based standards. In-house scientific experts consult with product reviewers on product applications. Scientific guidance benefits both applicants and review staff in developing and reviewing applications FDA Modernization Act requires FDA to recognize and use standards established by national or internationally recognized standard development organizations in the application review process, especially with medical devices. FDA's scientific efforts will allow the Agency to expand its participation in standards development and harmonization. Since data relating to the aspects of safety and/or efficiency covered by the standards will not be required in the premarket application, the review process can be expedited.

CDC – Infectious Diseases. CDC is committed to strengthening our Nation's capacity to recognize and respond to infectious disease threats, and our plan, *Addressing Emerging Disease Threats: A Prevention Strategy for the United States*, is being implemented. As we approach the 21st century, many important drug choices for the treatment of common infections are becoming increasingly limited and expensive, and in some cases, nonexistent. CDC's FY 2000 performance plan has been updated to include major program efforts for influenza pandemic preparedness, HCV infection, and antimicrobial resistance. In addition, each year CDC is instrumental in accurately tracking influenza strains around the globe, and as a World Health Organization Collaborating Center, using sophisticated techniques to provide scientific data essential for vaccine development.

NIH – Ensure that scientific and technology transfer staff have up-to-date information on legal requirements, policies, and procedures regarding technology transfer activities and responsibilities as a Federal employee.

NIH – Increase activity associated with marketing and licensing of available technologies by increasing the number of licensing agreements.

Selected FY 2000 Performance Goals and Measures

♦ Review and act on 90 percent of standard original New Drug Application (NDA), Product License Application (PLA) and Biologic License Application (BLA) submissions within 12 months of receipt (50 percent within 10 months); and review and act on 90 percent of priority original NDA/PLA/BLA submissions within 6 months of receipt. *FDA Plan*

♦ Review and act on 85 percent of complete blood bank and source plasma Product License Application (PLA) and Biologic License Application (BLA) submissions and 90 percent of PLA/BLA Major supplements within 12 months after submission date. *FDA Plan*

♦ Review and complete 85 percent of Premarket Approval Applications first actions for medical devices within 180 days in FY 2000 and 95 percent by FY 2002. Baseline: 51% (1996) *FDA Plan*

♦ Establish the capability and capacity to receive and archive Abbreviated New Drug Applications (ANDAs) submitted electronically. Baseline: Public comments on the industry guidance for the full NDA are resolved. (1998) *FDA Plan*

♦ Improve the detection of problems with medical devices, identify high risk medical devices, and prevent injury by using new reporting systems and procedures. FY 2000 measure: Develop Sentinel Surveillance System for injury reporting based on approximately 75 to 90 representative user facilities. *FDA Plan*

♦ Expedite processing and evaluation of adverse drug events through implementation of the Adverse Events Reporting System (AERS) which allows for electronic periodic data entry and acquisition of fully coded information from drug companies. *FDA Plan*

- Review and act on 65% of New Animal Drug Applications (NADAs) and Abbreviated New Animal Drug Applications (ANADAs) within 180 days of receipt. *FDA Plan*

- Complete 95 percent of Investigational Device Exemptions (IDE) "Agreement" meetings and medical device Premarket Approval Application (PMA) "Determination" meetings within 30 days. *FDA Plan*

- Maintain a 75 percent level for animal drug pre-submission conferences with industry sponsors. *FDA Plan*

- Complete 25 percent of the research projects started in FY 1999 under the auspices of the Product Quality Research Initiative, a collaboration among FDA, industry and academia established to provide a scientific basis for policy and guidance development in FDA on issues of drug product quality and performance. *FDA Plan*

- Establish technical program to support standards for computer- assisted diagnosis, body implant interactions and biosensors. *FDA Plan*

- 24 extramural awards will be provided to conduct enhanced research investigation to assist in development and improvement of diagnostic tests for use in areas such as antimicrobial resistance, sexually transmitted diseases, malaria, Lyme disease, health care associated infections, and blood safety. *CDC Plan*

- Annually contact scientific staff through scientific education activities, including the dissemination of policies, procedures, and guidelines that promote disclosure of inventions and appropriate patent protection and train staff on a new Web-based training module and by attendance at the Annual Technology Transfer Retreat. *NIH Plan*

- Increase the number of license agreements executed in FY 2000 by 3% over the previous fiscal year. *NIH Plan*

Programs Supporting This Objective

CDC
Infectious Diseases
FDA
Human Drugs
Biologics
Animal Drugs and Feeds
Medical Devices and Radiological Health
National Center for Toxicological Research
NIH
Research Program

HHS 6.6: Improve the Quality of Medical and Health Science Research by Strengthening the Base of Highly Qualified Scientific Investigators

From the HHS Strategic Plan, September 1997. The presence of a cadre of talented individuals in medical science and health services research is essential to improving the health of the nation. A robust and diverse research workforce—in laboratory, patient-oriented, population-based, and systems research—is central to carrying out the Department's mission and also to the vitality of present and future medical research enterprise and its associated industries.

Key FY 2000 Activities, Initiatives, and Strategies

- NIH – The continued success and vitality of medical research depends in large part on our most important national scientific resource -- the scientist. The NIH sponsors and conducts a wide range of training and career development activities to increase our ability to attract and retain the best and brightest minds in medical research and to develop a corps of highly skilled, well-trained individuals ready to "hit the road running" as post-doctoral researchers and principal investigators, and to enhance diversity. Our research training programs teach pre- and post-doctoral trainees how to conduct innovative, high-quality science, including how to choose problems, choose model systems, develop logical hypotheses, design experiments, conduct research with the highest ethical standards, and see connections among different fields that allow a scientist to make quantum leaps in understanding a problem. Career development programs ensure that we can retain and sustain these trained investigators who have the specialized knowledge, methodological expertise, and creativity essential to generating the scientific knowledge that will improve the health of Americans.

- The NIH has recently established three new career development mechanisms: (1) the K23 for the support of young investigators; (2) the K24 for the support of mid-career investigators in research and mentoring; and (3) the K30 for curriculum development in clinical research. The NIH Director's Panel on Clinical Research and the Institute of Medicine Committee on Addressing Career Paths for Clinical Research have recently addressed the need for strengthening national research capabilities in patient-oriented research. They identified a need to increase the pool of clinical researchers who can conduct patient-oriented studies, capitalizing on the discoveries of biomedical research and translating them to clinical settings. Among their recommendations were the initiation and improvement of training programs to enhance the attractiveness of careers in clinical research to medical students and mid-career clinical investigators.

- AHCPR – Nurture next generation of health services researchers. AHCPR will invest in four programs to further the training of health services researchers to address the research and analytic needs of the changing health care system. These priorities will build on prior efforts to make both curricula and practical research experiences more relevant to decision makers' concerns about the effectiveness of health care and issues of cost, quality, and access. Further, they will be designed to reflect and incorporate evolving innovations in data systems and research tools so that the researchers of the future not only identify and address significant research questions, but also employ cutting edge methodological, analytic, and data handling techniques, including appropriate privacy and confidentiality safeguards.

SAMHSA - The Faculty Development Program (FDP) administers education and training programs to improve clinical teaching about substance abuse by offering training to academically based faculty in primary health care and mental health and incorporate instruction about the prevention of alcohol and drug use in their ongoing clinical activities.

CDC – Epidemic Services. Epidemic services cover a vast spectrum of activities which include the training of public health epidemiologists and preventive medicine residents. Through the Epidemic Intelligence Service (EIS) and the Preventive Medicine Residency (PMR), CDC provides training to public health professionals so that they attain proficiency in applied epidemiology and preventive medicine. Both participants and graduates of these programs help CDC carry out its mission to prevent and control disease and injuries, and provide epidemiologic service to the state and local health departments.

In addition, in 1998, the Public Health Informatics Fellowship was implemented to develop a cadre of qualified professionals who can address the increasingly sophisticated information needs of public health programs in areas such as automated reporting of notifiable conditions, rapid dissemination of data from public health surveillance and outbreak investigations, and expeditious access to prevention and practice guidelines.

CDC – Infectious Diseases. CDC's efforts in infectious disease prevention focus on preventing illness, disability, and death caused by infectious diseases through various strategies. One of these strategies involves the delivery of training and information to the public health workforce using a variety of methods (self-study, computer-based training, satellite teleconferences, audio conferences, etc.) through the Public Health Training Network, as well as through other efforts. Training and education ensure that current and future generations will be prepared to respond to infectious disease threats.

Through the National Food Safety Initiative, national capacity to identify and control foodborne disease outbreaks be built through the training of epidemiologists and laboratorians.

Selected FY 2000 Performance Goals and Measures

♦ To strengthen the scope and nature of extramural public health research programs, CDC will conduct periodic assessments of extramural public health research programs that:

Increase the number of young investigator and public health research training opportunities in schools of pubic health and other programs of public health training; and

Increase the number and scope of training programs for specialties critical to advancing public health research and development. *CDC Plan*

♦ **Maintain a continuing supply of well-trained medical researchers.** Review and respond to the quadrennial assessment (expected February 1999) of the nation's future need for biomedical and behavioral research scientists prepared by the National Academy of Sciences. This report makes specific recommendations regarding the number of training positions to be

supported in broad disciplinary areas and provides NIH with numerical targets for training programs in future years. *NIH Plan*

- **Increase the pool of clinical researchers who can conduct patient-oriented research.** Issue at least 80 awards each in the K23 (support of young investigators) and K24 (support of mid-career investigators in research and mentoring) categories over the course of the fiscal year. *NIH Plan*

- The number of health service providers participating in distance learning activities annually will be increased from 105,000 in 1999 to 110,000. *CDC Plan*

- Training will be provided to at least 18 states in *Calicivirus*, *Bartonella*, and *Ehrlichia* diagnostics. *CDC Plan*

- 60 Public Health Microbiology Fellows will be trained and available for employment in local, state and federal public health laboratories. *CDC Plan*

Programs Supporting This Objective

AHCPR
Research on Health Costs, Quality, and Outcomes
CDC
Prevention Research
Epidemic Services
Infectious Diseases
NIH
Research
Research Training and Career Development
SAMHSA
Knowledge Development and Application

HHS 6.7: Ensure That Research Results Are Effectively Communicated to the Public, Practitioners, and the Scientific Community

From the HHS Strategic Plan, September 1997. The expeditious communication of research results is a vital step in translating new knowledge into changes in medical practice and into technologies that improve human health and well-being. Effective communication of research findings drives scientific innovation, fosters new discoveries, and ensures that public investment in research yields new methods of prevention, diagnosis, and treatment.

Key FY 2000 Activities, Initiatives, and Strategies

AHCPR – This phase of the cycle of research bridges the gap between the development of new knowledge and its implementation in the health care system. It is a phase that AHCPR is placing increased emphasis on as illustrated by the FY 2000 budget priority (3), Accelerating the Pace of Quality Improvement. Building on the previous 10 years of research findings, AHCPR will identify ongoing gaps between what we know now and what we do in health care and will begin to close those gaps through research and demonstrations that develop and test implementation strategies in different settings in the health care system. A major focus within this is identifying existing implementation strategies in use in health care settings and demonstrating their applicability to wide spread dissemination in other areas of the system.

AHCPR places considerable focus on developing tools and products that facilitate the transfer of research findings into practice. The Agency has a well developed dissemination system that includes publications development, the Publications Clearinghouse, and an award winning Web site. This emphasis is critical to the Agency's success. Ongoing plans include incorporating regular customer feedback into our operations to continue to improve our efforts.

AHCPR recognizes that it is unable to undertake bridging this gap with its resources alone. A major aspect of the Agency's approach is to leverage its own resources through the development of partnerships. These partnerships, within HHS, with other Federal agencies, and with private sector professional and consumer advocate organizations, enable the Agency to create distribution mechanisms for its information, products, and tools. The FY 2000 initiative "Accelerating the Pace of Quality Improvement" provides an increased commitment to translating research into practice. The Agency also will continue to focus on its own distribution mechanisms, such as the Agency's publications clearinghouse, to ensure that they are effective in disseminating Agency products.

CDC – CDC focuses on assuring the public's health through the translation of research into effective community-based action. This goal is oriented towards developing the capacity of public health departments to carry out essential public health programs and services, and involve community institutions and community groups in health promotion and disease prevention. As CDC strengthens its ongoing relationships with State and local health agencies,

it is also committed to building partnerships with non-governmental organizations at the community and national levels. These partnerships are essential for the design, implementation, and evaluation of sound prevention programs. What people understand about their health and potential risks to their health is of major concern in public health. CDC is committed to promoting effective health communication, conveying information to appropriate populations, and facilitating access to health information. The agency seeks to enhance the public's health knowledge through communication that is congruent with the values of diverse communities.

CDC – To ensure the scientific foundation of public health practices, CDC coordinates the development of the *Guide to Community Preventive Services*. This *Guide* provides public health practitioners, their community partners, and policy makers with evidence-based recommendations for planning and implementing population-based services and policies at the community and state level.

FDA – FDA is committed to providing clear, up-to-date information to consumers and patients that they need to make health care decisions and to use health products appropriately. The Agency is aware of the growing diversity of consumer health needs and interests. FDA will continue to implement targeted public awareness campaigns such as the *Food Safety Program's BAC!*, *Mammography Awareness Seminars*, and *Over the Counter (OTC) Labeling Changes* and will continue to make information about newly approved products, product labels and a range of health issues available on the Internet in language consumers can understand. The Internet is being used not only to disseminate information to consumers but also to obtain their input on various issues of interest to the Agency. The *FDA Consumer* and other printed materials, many of which are available in several languages, are provided to persons who are without Internet capabilities. A general telephone number and several special interest hotlines are also available to consumers who have specific questions about FDA-regulated products. Public Affairs Specialists in FDA's field offices will continue to play a key role in furnishing up-to-date information about new and emerging products to interested consumers.

FDA – FDA is responsible for ensuring that drugs, biologics, medical devices and food are safe, effective and appropriately labeled. In addition to reviewing new drugs, biologics, medical devices and food additive products, FDA plays a key role in disseminating information about these new products to health professionals and in ensuring the correct use of these products.

FDA continues to collaborate with industry to inform physicians, patients and consumers about new drugs and food items. In FY 2000, FDA will continue to make information about newly approved products, product labels, correct use of medications, and risk information about FDA-regulated products available to health professionals, consumers and other interested persons on the Internet. FDA also has an outreach program for physicians to inform them of new drugs available to their patients. Information is also available on new therapies approved by foreign countries before the FDA approves them.

FDA – Although FDA-regulated products are rigorously tested during the premarket review period, certain rare adverse effects of products are not recognized until after a product is in

widespread use. When new health risks related to FDA-regulated products are recognized, FDA ensures that manufacturers, health professionals, and consumers are alerted and corrective actions are taken.

MedWatch, the FDA Medical Products Reporting Program, is an initiative designed both to educate all health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events and problems to FDA and the manufacturer; and to ensure that new safety information is rapidly communicated to the medical community and that patient care improves as a result. FDA uses a variety of means to provide feedback to the health care community about safety issues involving medical products, including "Dear Health Professional" letters, safety notifications, product recalls, and product label changes. These are available on the Internet and in print.

FDA – Communication of research results to the scientific community. FDA communicates its research findings in professional journal publications, at national and international scientific meetings, and other appropriate forums. FDA sponsors a Science Forum annually, which government and other scientists attend, and workshops to address crosscutting topics. In addition, FDA holds periodic meetings with its stakeholders to discuss research findings, gaps in scientific knowledge, and research and program priorities; to develop creative and innovative strategies; and to review progress made toward Agency goals.

FDA – Exchanging Scientific Expertise. Industry and FDA collaboration creates an atmosphere that encourages the exchange of scientific expertise. In addition, FDA sponsors workshops on cutting edge topics such as gene therapy and Simian Virus and DNA vaccines. Agency scientists are also encouraged to publish their research findings in professional journals so their non-government peers can learn from their work.

NIH – Communicate the results of NIH research through health information and education programs for diverse audiences. NIH's research mission of developing new knowledge that leads to better health for all Americans is strengthened through communications programs that well inform the public about the results of health-related research. Each of the NIH Institutes and Centers directs programs for collecting, disseminating, and exchanging information on medical science and health. These efforts seek to raise public awareness of the benefits of medical research and to encourage the application of NIH-sponsored research results. Activities this fiscal year include expanding programs on anxiety disorders to audiences for whom language or literacy are challenges and who have a disproportionate burden of disease and pursuing new outreach or collaboration initiatives with professional associations of journalists, science writers, and health communicators.

NIH – Increase awareness of clinical research and recruit for Clinical Center trials. The Warren Grant Magnuson Clinical Center is the hospital that serves the intramural clinical research needs of the NIH. To enhance and support that research, a steady, diverse, and substantial pool of patient and normal volunteers is necessary. The quality of clinical research and its ability to improve the public's health care depend on the nation's physicians having the opportunity to refer patients to current studies and on patients having the information they

need to learn about and participate in clinical trials. Activities to be initiated include: developing methods and materials vital to the communication with and recruitment of minorities and ethnic groups, whose participation is critical to serving the health-care needs of the public; enriching interactions with physicians wishing to participate in NIH clinical research by referring patients to clinical trials; building networks of communication and support among the NIH and community groups and organizations locally, regionally, and nationally; strengthening communications with the general public and potential research volunteers to stimulate their interest in and understanding of clinical research and its affect on the betterment of health care; and developing a solid foundation of internal supports for the entire communication and outreach program.

NIH – Improve the National Library of Medicine's customer service and information services for individuals seeking medical information. The National Library of Medicine (NLM) collects, organizes, and makes available biomedical science information to investigators, educators, and practitioners and carries out programs designed to strengthen medical library services in the United States. Its electronic databases, including MEDLINE, are used extensively throughout the world. The NLM's 1997 introduction of free searching of its MEDLINE database of journal article references via the Web has proved very popular. The other major parts of NLM's "medical literature" collection, namely books, audiovisuals, and serial titles, are not yet served by direct Web access. These three catalog databases are today primarily used by librarians who are trained searchers. Opening the databases up to the public via easy Web access should greatly increase their usage.

NIH – Improve the accessibility of information to the public by exploiting new technologies for information dissemination. New information technologies offer unprecedented opportunities as powerful new communications tools. It is important for NIH to take full advantage of the methods that underlie the World Wide Web (Web), telemedicine, and imaging projects in order to better serve those who need immediate access to NIH's medical and scientific information and resources. Providing NIH audiences better access to health information and medical research resources will help advance the NIH mission. Planned initiatives and activities include: increasing the usage of the NIH and IC home pages; funding a series of demonstration projects applying telemedicine and other technology to improve the speed of reaching heart attack victims with lifesaving treatment; and using telehealth technology and TV cable networks to mount education projects with nursing organizations and academic institutions.

SAMHSA – The Knowledge Exchange Network program is a clearinghouse designed to ensure widespread dissemination of information about mental health resources and research results. The Addiction Technology Transfer Centers program disseminates multi-disciplinary, clinically relevant, research based information about substance abuse for practitioners. Working in conjunction with The Office of National Drug Control Policy, SAMHSA supports the National Clearinghouse for Alcohol and Drug Information (NCADI) which responds to thousands of requests for public information.

- SAMHSA – The Prevention Enhancement Protocol System (PEPS) collects, synthesizes, translates and disseminates research and practice-based findings in useable form for application in communities. PEPS is a pioneering initiative that develops program and intervention guidelines for the field using established "rules of evidence" for assessing practice and research findings and combining this evidence into prevention approaches.

- SAMHSA – The National Center for the Advancement of Prevention II (NCAP II) develops, synthesizes, adapts and disseminates state-of-the-art prevention knowledge about what works in prevention, for whom, and under what conditions. NCAP II makes knowledge-based tools, principles and models useful for developing prevention plans and programs available to States, communities, and local prevention practitioners and policy makers to improve the effectiveness of prevention efforts across the nation.

- SAMHSA – The State Incentive Grant (SIG) Program extends CSAP's ability to help States improve their prevention service capacity. Funding enables States to examine their state prevention systems and redirect resources to critical targeted prevention service needs within their states. Eighty-five percent of SIG funds are directed toward implementing best practices within local programming to reduce the gap in prevention services. In this way SIG funds not only help improve access to needed services, they also improve the quality of the prevention services provided. SIG States are also field testing their core measures to assess their feasibility for use in reporting on block grant activities, creating Statewide networks of public and private organizations to extend the reach of the primary prevention portion of the SAPT Block Grant and optimizing the application of State and Federal substance abuse funding streams.

- IHS – Treatment and Prevention. The IHS maintains an infrastructure to support mission critical research and its dissemination to health care providers and the scientific community which includes an annual research conference, a peer reviewed journal for IHS health care providers, and the IHS institutional review board.

- OPHS – Healthfinder. Usage of the popular consumer health gateway, www.healthfinder.gov, is growing at a rate of 10-15 percent per month and serves users whose information needs range from simple introductory texts to technical resources on diseases, treatments, and health care systems.

- OPHS – To increase awareness and understanding of the major health problems and needs of racial and ethnic minorities and the nature and extent of health disparities between racial/ethnic groups in the U.S., OPHS supports resource centers (e.g, the OMH Resource Center and the OWH Information Center) and clearinghouses (e.g., ODPHP's National Health Information Clearinghouse) that respond to public inquiries and disseminate information and educational materials on a range of disease prevention and health promotion, women's health, and minority health issues. Widely available access is assured by using toll-free telephone lines, electronic and regular mail, web-sites (such as healthfinder and the National Women's Health Information Center), publications (including newsletters and Surgeon General's reports), exhibits, speaking

engagements, and media appearances as venues for communicating with the public and other OPHS partners.

Selected FY 2000 Performance Goals and Measures

- Establish a National Center for Health Statistics (NCHS) Data Center, which will allow non-NCHS researchers to access detailed data files in a secure environment, without jeopardizing the confidentiality of respondents. This Data Center will greatly expand the range of research and analytic efforts that can take advantage of data that NCHS has already collected. *CDC Plan*

- Complete the pilot study of the Multimedia *Morbidity and Mortality Weekly Report* (MMWR) project in which information from the MMWR series of publications is distributed to the media, public, policy makers, and health professionals through multiple media channels – print, television, radio, interactive World Wide Web – using advanced telecommunications technology. *CDC Plan*

- Release vital statistics in new formats to speed the release of data on high-priority topics. (e.g., *Teenage Births in the United States: National and State Trends 1990-96*) . FY 2000 measure: Release 1 report in such format. *CDC Plan*

- Maximize the distribution and use of scientific information and prevention messages through modern communication technology. Sample FY 2000 measure: Evaluate market penetration by analyzing data collected through Nielsen's Sigma encoding; reports of market rank (Nielsen), market area, air date and time, estimated viewing audience, and estimated advertising value; Internet hits; audio/video downloads; media contacts; and CIO-specific communications evaluation. *CDC Plan*

- Prevention research and demonstration centers receiving supplemental or initial financial assistance through the FY 1999 funds will be required to disseminate information on candidate interventions and results of field tests of interventions through publications and scientific presentations. *CDC Plan*

- The 14 university-based Prevention Research Centers will conduct at least two educational sessions per year for public health practitioners and community leaders, focusing on core disciplines in public health, intervention methods, translation, or evaluation. Baseline: 2 Educational Sessions (FY 1999). *CDC Plan*

- Make new drug approval information increasingly available and targeted and promoted to specific user groups such as consumers, patients, health-care practitioners and industry via the Internet, resulting in a decrease in serious medication errors. *FDA Plan*

- Make available in consumer understandable language via the World Wide Web information on all New Molecular Entities (NMEs) within 3 days of approval. *FDA Plan*

- Post all new drug approval information to the CDER web site within two weeks of approval (including the approval letter, labeling text or label if applicable, review and, for innovator drugs, consumer and prescribing information). *FDA Plan*

- Ensure that no less than 85% of respondents to a customer feedback instrument rate NLM services at least satisfactory. *NIH Plan*

- Increase usage of NLM's existing catalog-based databases for books, serials, and audiovisual materials by at least 25%. *NIH Plan*

Programs Supporting This Objective

AHCPR
Research on Health Costs, Quality, and Outcomes
CDC
HIV/AIDS Prevention
Sexually Transmitted Diseases
Tuberculosis
Diabetes and Other Chronic Diseases
Heart Disease and Health Promotion
Breast and Cervical Cancer Prevention
Prevention Centers
Infectious Diseases
Lead Poisoning
Health Statistics
Prevention Research
Epidemic Services
Environmental Disease Prevention
Occupational Safety and Health
Eliminating Racial and Ethnic Disparities

FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
National Center for Toxicological Research
Tobacco
IHS
Direct Operations
NIH
Research
OPHS
Office of Disease Prevention and Health Promotion
Office of Minority Health
Office of Women's Health
Office of the Surgeon General
SAMHSA
Knowledge Development and Application

APPENDIX:

APPROACH TO PERFORMANCE MEASUREMENT, MEASUREMENT CHALLENGES, AND IMPROVEMENTS IN THE PERFORMANCE PLANS OF HHS COMPONENTS

The Department of Health and Human Services (HHS) is a large Federal Department that provides leadership in the administration of programs to improve the health and well-being of Americans, and to maintain the United States as a world leader in biomedical and public health sciences. The programs of the Department impact all Americans, either through direct services, the benefits of advances in science, or information that helps them choose medical care, medicine, or even food. Through Medicare and Medicaid, for example, HHS oversees the administration of the nation's largest health insurance programs, serving an estimated 72 million Americans. Through numerous grants and other financial arrangements with public and private service providers, HHS is committed to improve health and human service outcomes and the economic independence of individuals and families throughout the US.

As set forth in the laws that established the programs administered by HHS, partnership in administration is the central and fundamental management approach for program implementation and service delivery. The overwhelming majority of the approximately $400 billion dollars that will be expended for HHS programs in FY 2000 will be spent, not by HHS employees, but by program partners. The States, not the Administration for Children and Families (ACF), spend the funds that support the income assistance provided under Temporary Assistance for Needy Families (TANF). More than $8 out of every $10 appropriated to the National Institutes of Health (NIH) goes to the scientific community at large. Large fiscal agents such as Blue Cross and Blue Shield and Aetna pay the doctors, hospitals, and other health care providers that serve Medicare and Medicaid beneficiaries. It is through collaboration with States, local and tribal governments, and non-governmental partners that HHS must set and accomplish the program goals and objectives that produce results for people with the enormous annual investment entrusted to the Department. The diversity and scope of HHS programs are also reflected in the large number of Congressional appropriations and authorizing committees and subcommittees involved in the determination of HHS resources and program strategies.

The primary and most substantive means of producing results with these investments are not the management strategies and processes that are developed by Federal program managers, although these can and do improve the efficiency and effectiveness of service delivery for programs that serve people. Rather, the significant Federal strategies that produce the results that GPRA seeks to measure are the program strategies that the Congress has authorized in legislation and that HHS and its partners execute. The means of success for HHS are its programs in basic and applied

science, public health, income support, child development, and the financing and regulation of health and social services.

As a result of these two major factors, HHS performance assessment focuses on the results that HHS and its partners produce through the programs and resources entrusted to them. HHS's annual performance plans are not internal management documents that focus on the methods and strategies employed to issue grants, contracts or cooperative agreements. Rather, they are public documents that inform the Congress about program goals and objectives of HHS and its partners, about program strategies defined in large part by law, and about measures of program results that affect people.

The HHS FY 2000 Performance Plan consists of this summary and the HHS Operating Division performance plans, which are incorporated into their FY 2000 budgets. The summary provides the overall Departmental context for the plans, demonstrates how HHS's performance goals and measures support the HHS strategic plan, and addresses performance measurement challenges for the Department. The Operating Division annual performance plans include performance goals and measures for HHS'sprogram activities and the linkage to the budget that is critical to the GPRA requirements for annual performance plans.

INTEGRATION OF THE HHS PERFORMANCE PLAN AND BUDGET

Just as OMB Circular A-11, Part 2, has stipulated that "the program activity structure is the foundation for defining and presenting performance goals and indicators," HHS has determined that the Budget of HHS, which describes HHS program activities and necessary resources, provides the structure for the development and presentation of an annual performance plan for an agency that administers some 300 program activities. The decision to present performance information in the format of the budget reflects HHS's intent to enhance its budget justification and decision making with performance measurement information, and to be attentive to the many Congressional committees that play a role in the Department's budget.

There are other significant advantages to incorporating the Annual Performance Plan into the HHS Budget. The Budget routinely describes program activities and specifies associated resource needs, which is information that is also required by GPRA for inclusion in annual performance plans. Combining the performance plan and the budget ensures the consistency of information used for budget and performance planning purposes. Finally, because the HHS Budget routinely covers all HHS program activities, including the performance plan in the Budget provides the framework to ensure that performance information fully covers these activities as well.

As a result, just as the HHS budget request is presented in multiple volumes that address the resource needs and justifications of the individual operating and staff components of HHS, so also is the HHS annual performance plan presented in the same manner. The detailed and substantive information that fully explains program-level performance and that constitutes the plans for the individual HHS components is included in the budget presentations and annual performance plans

of those components. A thorough understanding of HHS program-level performance information requires the study of the annual performance plans included in the Congressional budget justifications of the HHS Operating Divisions.

PERFORMANCE GOALS AND INDICATORS

The most important aspect of the HHS Annual Performance Plan is the performance goals and indicators for FY 2000 for HHS's program activities. All HHS programs are represented in the Annual Performance Plan by quantitative or qualitative performance goals and indicators, and many of these goals and indicators are related to program outcomes. HHS's annual performance goals and indicators, which are presented and explained in detail in the individual budget and performance plan submissions of HHS components, provide a definitive portrait of what HHS and its program performance partners will achieve through HHS programs in FY 2000. In addition, the goals and measures go a long way toward explaining how resources administered by and through HHS are used, and what results are to be accomplished with these resources.

As the General Accounting Office observed in its March 1997 Report, *"The Government Performance and Results Act: 1997 Government-wide Implementation Will Be Uneven,"* performance measurement under the GPRA rubric will be an iterative process. In fact, performance information gaps existed for some HHS programs in the FY 1999 Annual Performance Plan. With this submission, the HHS Operating Divisions have made significant improvements in both their FY 1999 and FY 2000 performance plans. These improvements reflect the knowledge gained by HHS Operating Divisions during the FY 1999 and FY 2000 GPRA implementation processes, the results of continued consultations with HHS's performance partners, the availability of new and/or enhanced data sources, and feedback received on the HHS FY 1999 Performance Plan.

There still remain significant challenges to annual performance measurement in HHS. Because the majority of issues that will continue to affect performance measurement apply to specific program activities, the performance plans of the HHS Operating Divisions address these issues in detail. Nevertheless, many of these apply more generally on a broader scale and warrant discussion here.

Data Validation Challenge

The range and diversity of programs implemented by the Department have contributed to one of the most critical challenges in the implementation of GPRA within HHS. The absence in many cases of timely, reliable, and appropriate data from performance partners is a critical limiting factor in developing performance objectives, goals and indicators for HHS programs. As is discussed in the Department's Strategic Plan, this issue applies throughout the Department for many program activities, the details of which are explained in component plans.

It is related significantly, however, to the decentralized and distributed nature of program implementation throughout the Department and to the extensive involvement and authority of non-Federal partners in program implementation and management. Existing data systems were

frequently established to monitor the use of resources and to provide aggregate data that does not capture the outcomes of activity. In addition, many Federal surveys are not conducted annually and do not provide State-specific data or data that tracks special population groups. As a result, many HHS programs will rely on data for performance measurement that is now collected for other purposes.

Data validation, which is a fundamental GPRA requirement, will also be a challenge for many HHS components. Because programs and sources of performance information are so varied across the Department, the summarization of data validation is not feasible. It is addressed by the individual HHS components in their performance plans. Nevertheless, a common attribute of validation across the Department is that it will be resource intensive and require extensive coordination with performance partners.

For a number of program activities, there are outcome goals and objectives for which baseline and target data are not currently available. This is related to the issue of data validation, but also warrants a separate mention because the establishment of baselines is a fundamental requirement of GPRA. This is a good example of the need to assess GPRA implementation as an iterative process. Wherever possible, HHS and its components will identify baseline and target data as program managers and their performance partners are able to do so.

Types of Measures: Outcome vs. Output and Process

HHS has included a balance of outcome, output and process measures throughout the annual performance plan. Through most of its programs HHS seeks to directly affect the health and well-being of individuals, and the Department should, where feasible, measure its results with data on program outcomes. However, as OMB Circular A-11, Part 2 anticipates, measures of output can be the predominant indicators in an annual performance plan. Output and process measures, in fact, inform more completely about program performance than do outcome measures, so reliance on them should be substantial. In addition, the HHS plan focuses on annual results and in those instances where outcomes will require years to achieve, or where the cost of annual outcome measurement would be exorbitant, output measurement is essential and preferred on an annual basis. Where the contribution of a Federal agency to the production of outcome is not realistically measurable, efficiency and customer satisfaction may be assessed on an ongoing basis. Finally, the most critical results for some program activities are not always outcomes. Frequently it is the processes associated with Federal programs, regulations and activities that have the greatest impact on people and industries; and improving the timing and quality of outputs and processes may be the most appropriate and effective objectives for such programs. For example, measuring improvement in health outcomes will not provide a quantitative assessment of FDA's contribution to the nation's health – ensuring that new drugs and biologics are made available for use in a safe and timely fashion.

Nevertheless, some HHS components have initially made greater use of process and output measures than they will in the future because of the lack of adequate data to measure performance outcomes or the need to work with their performance partners to develop mutually agreed upon outcome goals and measures. As a result, future iterations of the HHS Annual Performance Plan

will include more outcome measures. A review of component performance information will identify where these circumstances occur.

Performance Partners and Stakeholders

Related also to the first two issues identified above, is the necessity to involve partners and stakeholders in the development of performance objectives and measures. As indicated in the introduction, the vast majority of funds administered through HHS are expended by groups outside the Federal government, particularly State and local agencies, non-profit groups, universities, insurance companies and health-care practitioners. In addition, numerous others in the community match, supplement or coordinate services funded by HHS and comparable service agencies. HHS's experience with performance measurement pilots and performance partnerships has demonstrated that HHS must include these performance partners and stakeholders extensively in the development of performance goals and measures, and must rely on them for much of the information that will serve to assess the results produced by HHS programs. Achieving this in a manner that avoids prescriptive and burdensome requirements and allows maximum program flexibility at the local level is a prominent challenge for any Federal agency, but particularly for HHS because of the extent of its reliance on outsiders for program performance.

Coverage and Aggregation of Program Activities

The HHS annual performance plan provides performance information for a mixture of direct and aggregated program activities, but coverage of major HHS program activities is complete. HCFA, NIH and ACF have aggregated program activities as permitted by the GPRA, and have explained the rationale for aggregation in their parts of the HHS plan. Others, such as CDC and FDA, have elected to provide performance information for all program activities traditionally displayed in the President's budget. HRSA has aggregated selected program activities in order to better measure program outcomes. For reporting and presentation purposes, each approach allows for substantive performance information that is meaningful to HHS and the Government as a whole.

KEY IMPROVEMENTS TO THE HHS FY 2000 PERFORMANCE PLANS

The second year of GPRA implementation has seen a growing maturation of the planning process. Senior management and budget staff have become more involved in planning, and this has furthered the process of integrating performance measurement in strategic, management, and budget decisions throughout HHS. In addition, the HHS financial management community has revised the HHS Financial Management Five-Year Plan, covering fiscal years 1999 through 2003, to include concise, quantifiable goals and performance measures for financial management activities throughout the Department. This activity was coordinated with the Department's GPRA activities, and the HHS Operating Divisions were encouraged to include these goals and measures in their GPRA plans for "mission-critical" areas.

The significant improvements in the HHS FY 2000 Performance Plan reflect the knowledge gained by the HHS Operating Divisions during the FY 1999 and FY 2000 GPRA implementation processes, the results of continued consultations with HHS's performance partners, the availability of new and/or enhanced data sources, and feedback received on the HHS FY 1999 Performance Plan. Key improvements include the following.

- The FY 2000 HHS Performance Plan Summary has been expanded to include a new section, *Linking the HHS Strategic Plan and FY 2000 Performance Plans*. For each HHS strategic objective, this section provides key performance strategies, a list of HHS programs that support the objective, and selected FY 2000 performance goals for assessing progress towards achieving the objective.

- The HHS Operating Divisions have made significant improvements in their FY 1999 and FY 2000 performance plans. Some components have submitted a FY 2000 plan that includes the revised FY 1999 goals and measures, and some have submitted a revised FY 1999 plan in conjunction with their FY 2000 plans. The *HHS Operating Division* section of this summary includes a detailed discussion of these improvements for each Operating Division. In summary, these improvements include:

    - A more focused set of measures based on the best and most recent available data. Where appropriate, these improvements were also applied to FY 1999 goals and measures. Changes and deletions to specific FY 1999 goals and measures and an explanation of the rationale for the changes are detailed in the HHS component plans.

    - More complete coverage of program activities and initiatives. For example, HCFA, which received a waiver of GPRA rules for the Medicaid program from OMB for its FY 1999 plan, has identified Medicaid goal areas that are being developed jointly with the States. Also, goals and measures have been included for several new programs and cross-cutting initiatives.

    - New outcome-oriented performance goals that speak to fundamental program purposes. In addition, HHS components have provided clearer linkage between the achievement of capacity and process measures and longer-term program objectives.

    - More estimates for baselines and targets due to continuing work with performance partners and development of data sources. When baselines and targets are not yet available, HHS components have included commitments for when they will be available and discussions of the reasons for the delay, such as continuing consultations with partners, new or recently consolidated programs, and the need to enhance existing data sources or develop new data sources.

    - More extensive internal and external communication and coordination by cross-cutting programs. In addition, HHS Operating Divisions included more complete discussions of communication and coordination between cross-cutting programs in their plans.

- Expanded discussions of data sources, data limitations, data validation and verification, and evaluations that support performance measurement efforts.

HHS OPERATING DIVISIONS

The following summaries provide a general description of the mission and programs of each of the HHS Operating Divisions, how the performance goals and objectives of the individual HHS Operating Divisions supports the HHS Strategic Plan, how these varied Operating Divisions have approached the implementation of GPRA requirements for annual performance plans. We also summarize the data challenges for each component, reflecting the variety of challenges that HHS faces in measuring performance under GPRA, and list key improvements to the FY 2000 plans.

Administration for Children and Families

Overview

The Administration for Children and Families (ACF) administers programs that promote the economic and social well-being of children, youth, and families, focusing particular attention on vulnerable populations including low income children, refugees, Native Americans, and the developmentally disabled. These programs derive from dozens of legislative authorities and a diversity of funding and governance arrangements. ACF provides leadership, coordination, technical assistance, evaluation and Federal funding; State, local, or community-based organizations or non-profit grantees deliver program services.

ACF and its partners are jointly responsible for the success of programs that support several HHS goals and provide primary program support for the HHS goal to *improve the economic and social well-being of individuals, families, and communities in the United States*. To that end, ACF and its partners have developed performance goals and measures that will track their success in increasing employment, independent living, affordable quality child care, parental responsibility, and improvements in the health status, safety, and permanency of children and youth.

ACF also coordinates its programs with other HHS agencies, particularly those that provide medical and dental services and health insurance to low income families, including the Administration on Aging, the Health Care Financing Administration, Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration.

Other Federal agencies have related goals that complement and supplement ACF's goals, including the Departments of Labor (improving job readiness and employment among low income people), Housing and Urban Development (improving the quality and supply of inexpensive housing), Agriculture (assuring that the nutritional needs of low income people are met), Transportation (helping welfare recipients obtain affordable transportation to the workplace), Education (improving early education efforts and readiness to work skills), and Justice (supporting non-violence programs). ACF participates in a number of interagency workgroups that work to assure coordination among these programs.

Approach to Performance Measurement

ACF administers 22 legislative programs, divided among 35 budget activities. To encourage individual programs to collaborate on the achievement of ACF-wide cross-cutting program goals, ACF aggregated these activities into thirteen major program areas that support four ACF strategic goals. Under these goals, ACF established eight cross-cutting strategic objectives that will facilitate movement toward more outcome-based measures. These goals and objectives provide the structure for ACF's performance plan.

ACF's programs are administered in a complex partnership with Federal, State, Local, non-profit and community-based organizations that carry out programs and deliver services around the country. The relationships, funding mechanisms and degrees of autonomy vary from program to

program. A primary challenge is for partners to collaborate in crafting effective policies and programs that satisfy mutually agreed-upon objectives. The broad goals of these diverse jurisdictions and organizations are similar to ACF's, but State and Local programs often differ on specific targets and outcomes relevant to the particular needs of specific population groups and communities. In this decentralized environment, ACF's ability to achieve its goals and objectives depends on working effectively with State, Local, and tribal governments and other stakeholders.

Recognizing this, ACF has engaged in extensive consultation with its partners and stakeholders both to learn from their experience and gain their support for the achievement of mutually agreed-upon performance goals and measures, allowing for maximum flexibility at the Local level. These discussions have included not only direct partners but also advocacy groups and national educational/technical assistance organizations. This effort to reach consensus on outcomes has prompted extensive discussion of strategic objectives, legislative requirements, and data sources and has led to a fuller understanding of the desired program outcomes and the relationship of process and output measures to those outcomes.

The expected results will vary across goals and objectives depending on the nature of the issues, the identification of appropriate measures, and our ability to collect the data. In areas where results are quantifiable and where data are available or more easily obtained, such as for child support collections, ACF expects to report on results sooner. In other areas, where expected outcomes are qualitative or depend on the agreement of State and Local agencies to provide data, considerable effort will be needed to achieve consensus on the appropriate outcomes and measures of success, and to implement appropriate systems for data collection. This is illustrated by ACF's efforts to measure high performance under welfare reform, its efforts to measure quality in Head Start, and by the newly legislated expectations for child protective services, foster care, and adoptions.

Data Issues

ACF has identified a number of data issues that affect its ability to collect data to report on program performance, including the following:

- Quantitative and qualitative measurement of outcomes in social programs are in the early stages of development.

- States, Tribes and non-profit grantees vary in their ability to collect, produce and report reliable data. Data validation and verification will be highly complex.

- Particularly for our numerous new or changed programs, baseline data are frequently unavailable and must be developed before progress can be measured. In the case of Head Start, some baselines await the completion of extensive new research that is following a cohort of Head Start children over several years.

- Data collection systems fully geared to State flexibility are still being implemented.

- Investments for the design, development and implementation of data collection systems are costly and must be balanced against other priorities, at the Federal, State and Local levels.

Key Improvements to the FY 2000 Plan

ACF has made a number of improvements in its FY 2000 Annual Performance Plan. The FY 2000 plan includes information on which targets are new, which have been discontinued and which are still developmental. Each of the ACF programs was asked to re-examine its measures and targets, and many programs created a more focused set of measures by dropping measures, providing improved measures and targets based on the most recent available data and by narrowing and refining existing measures. For the most part, changes have been made as a result of new and/or improved data and data collection systems.

Additionally, under each of the strategic goals and objectives, performance goals and measures are discussed in more detail, along with strategic approaches, considerations of external influence and coordination, resources, and data issues, including frequency of reporting. Since most of ACF's programs do not anticipate significant changes in funding from 1999 projections, many performance measures and targets remain unchanged.

ACF has endeavored to project baselines for FY 1998 or FY 1999 wherever possible. A few measures still lack baselines, because programs are undergoing implementation with new initiatives and new data collection activities. Baselines for those measures will be set in future years, upon completion of start-up and developmental activities. In a very few cases, the targets or measures are stated in ways that make baselines unnecessary (e.g., continuous improvement targets or legislatively-defined targets); for those we have provided a context in the narrative.

More descriptive information has been provided in a number of areas: (1) a presentation of how the inputs and outputs of the Social Services Block Grant (SSBG) program support other ACF program outcomes; (2) a more comprehensive discussion of data issues and concerns under each of the program areas; (3) a revision of certain goals and measures to use the same baseline data for both FY 1999 and FY 2000 wherever possible; (4) an update and expansion of the budget cross-walk, providing more detailed information on programs included under the thirteen areas of aggregation; and (5) a status update on FY 1999 measures.

The FY 1999 targets are shown alongside the FY 2000 targets. Based on implementation experience in FY 1999, following the receipt and analysis of data (which will be available in the spring of 2000), measures and targets for FY 2001 may be revised and improved.

Administration on Aging

Overview

The Administration on Aging (AoA) serves as an important service and advocacy agency for older Americans. Through a Statewide services delivery infrastructure, AoA-funded programs deliver comprehensive in-home and community services; and make legal services, counseling, and ombudsmen programs available to elderly Americans.

AoA accomplishes this mission in concert with its partners--the State, tribal and area agencies on aging, and the providers of services--that comprise the Aging Network. The results achieved by the Aging Network contribute to the HHS strategic goal to:

★ *Improve the Economic and Social Well-Being of Individuals, Families and Communities in the United States.*

AoA contributes to the successful accomplishment of this goal through its programs of community-based access services, nutrition services, Native American services, long-term care ombudsman, research and demonstration programs, and the Alzheimer's disease grants. The grant funding provided under these programs helps to fill the gaps in other Federal and State programs, for example, by providing services to people who are ineligible for other programs but who still need support. The ability to leverage and use funds for services from sources other than the AoA's funding under the Older Americans Act, is an essential systems outcome of the Aging Network.

Approach to Performance Measurement

In recognition of its role as advocate and source of funding to be leveraged and used for a variety of services determined by the State and Local providers, AoA has identified primarily output measures for services provided by the Aging network. Access of older Americans to services is a critical element of community-based services. Access is the result of the capacity and effective use of comprehensive and coordinated systems by the network, so the proposed measures for the level of service for such needs as information and assistance, transportation, and case management is important.

The output measures identified by AoA contribute to the successful outcomes for older Americans. For instance, the FY 1999 provision of 119 million home-delivered meals to over 988,000 people under the nutrition program directly contribute to the daily health and independence of Older Americans. The Long-Term Care Ombudsman program, which resolves or partially resolves more than 70% of complaints about long-term care services, helps to ensure the health and safety of nursing home residents.

As mentioned, the leveraging of funding is also essential for the network to be successful in providing services, so a performance target for the network's leveraging of the AoA funds has also been identified.

AoA measures its own accountability for its contribution to the health and independence of older Americans by improvements in the timely and accurate processing of grants, as well as improvements in its corporate data structure that supports its programs.

Data Issues

AoA will use the State and tribal program reports for Titles III, VI, and VII of the Older American's Act to assess both the performance of the network and the performance of the agency. These systems comprise the National Aging Program Information System (NAPIS). Begun in 1997, the NAPIS collects for the first time, unduplicated counts of recipients of services with breakdowns by cost, age, and ethnicity. The results of the initial reports under this system affect the baselines and targets identified by AoA. This data is aggregated information about program outputs, so it will be adequate for assessing the output performance measures; however, it does not report on outcomes. These reports will be supplemented by site visits and surveys.

AoA based several of its measures on a study of community-based services, and on evaluation studies of nutrition services and the long-term care ombudsman program. AoA has begun planning for the supportive services and senior centers under Title III of the Act.

Key Improvements to the FY 2000 Plan

The Administration on Aging's FY 2000 performance plan reflects several major changes in the way AoA does business, including:

- a movement toward evidence-based program design and operations;
- reliance on collaboration with other HHS agencies, other Departments and private sector institutions;
- a greater reliance on program outcomes.

AoA is using research-based knowledge to design services that are effective in meeting real human needs and compatible with the expectations and desires of the people who use the services. The development of an evidence-based approach to program design requires a core set of performance outcome measures with wide consensus. This is a major focus of AoA's activities, and is consistent with the Government Performance and Results Act.

Fiscal year 2000 is a transition year from AoA's exclusive reliance on output measures to move to an increased reliance on performance outcome measures.

The FY 2000 performance plan includes two budget initiatives that are featured as new line items: National Family Caregiver Support Program; and Health Disparities Interventions.

For these initiatives, AoA is using a set of one-year measures specific to the FY 2000 budget initiatives. Under initiatives supported by discretionary funding, performance information must be reported as a

condition of receipt of funds. Data requirements will be determined in collaboration with State and Local partners. Through this collaborative process AoA expects to establish baselines early in FY 2000.

In 1997, AoA initiated a project in collaboration with the National Association of State Units on Aging and the National Association of Area Agencies on Aging to develop, pilot-test and finalize a performance measurement system. Under this performance outcome measures project, funds are being made available to eight States and eight area Agencies on Aging that meet requisite preconditions. Study teams will visit each of the 16 sites to:

- collect material that describes the performance measures and methods used by each agency;
- identify the organizational and functional components of the agency using the measures;
- determine the types and sources of data the agencies use to construct the performance measure; and
- describe the computer systems and software the agency uses to collect and analyze the data.

Cross-site analysis will identify core service areas and performance measures in use in the pilot State and area agencies on aging. Recommendations for a core set of performance outcome measures suitable for adoption by the aging network at large will be developed. Participating State and area agencies will later field-test these performance outcome measures to determine their transferability to all other States and localities.

To spur discussion and promote consensus about the use of consistent performance outcome measures, a number of dissemination and utilization activities will be held in 1999, including a national conference.

Agency for Health Care Policy and Research

Overview

The Agency for Health Care Policy and Research (AHCPR) supports and conducts research that improves the outcomes, quality, access to, cost and utilization of health care services.

The variety of audiences addressed by AHCPR research – patients, their care givers, health care providers and insurers, plans, Federal, State, and Local as well as private sector policymakers, and researchers -- are provided with answers critical to informed health care decision making. New knowledge developed through research sponsored and conducted by AHCPR, translation of research findings into products and tools to facilitate implementation into the health care system, and dissemination activities provide these audiences with information necessary to make choices among available options, while taking into consideration their expectations for outcomes, quality of care, and costs. For example, AHCPR makes it possible for patients and their clinicians to make treatment choices based on information on the outcomes, effectiveness, and cost effectiveness of available treatments.

AHCPR works with the public, private sector organizations, experts, internal and independent researchers, to identify the needs for new knowledge, products, and tools. AHCPR's research and associated products also enable informed decision making and policy implementation by other components within the Department and the Federal government. For example, HCFA uses AHCPR research to perform its role in overseeing the cost and quality of medical services to Medicare beneficiaries, including critical decisions on coverage.

Because AHCPR is the focal point of the Department's health care quality efforts and because it provides new knowledge on what works, when, and at what cost in the health care system, AHCPR makes important contributions to five of the six HHS strategic goals, with particular emphasis on the HHS goals to:

★ Improve the quality of health care and human services, and
★ Strengthen the nation's health sciences research enterprise and enhance its productivity.

AHCPR's key strategies in FY 1999 for contributing to these goals are to:

- Conduct research that addresses the challenges facing the health care system related to the outcomes and quality of health care and the impact of ongoing market changes in the health care system on quality, cost, access, and utilization of health care services
- Coordinate and provide information that focuses on questions of great public policy interest.
- Exercise leadership for cross-cutting, interagency efforts to improve the quality of health care.

AHCPR will use the resources provided in its budget activities of Research on Health Costs, Quality and Outcomes (HCQO), Medical Expenditure Panel Surveys (MEPS) and Program Support to conduct these strategies and to work toward these HHS strategic goals. Research grants and survey

mechanisms as well as collaborations with partners are the vehicles for these resources and for accomplishing these strategies.

For example, grants awarded for investigator-initiated research in FY 1999 are expected to address: outcomes for the elderly and chronically ill, improvements in the quality of children's health, developments in the purchasing behavior of large employers and purchasing coalitions; changes in structure, financial mechanisms, and legal and regulatory framework of the health industry; new models of delivery of health care; "medical necessity" coverage issues; and the capacity to provide a coordinated package of services for patients.

Approach to Performance Measurement

The AHCPR FY 1999 Annual Performance Plan describes in more detail the performance goals, objectives, and strategies that the Agency will use to accomplish its mission, and the indicators it will use to assess its achievements. Outcomes of research programs are difficult to accurately measure and describe. Since a successful research program is an iterative and on-going process and since AHCPR is the provider of information to be used by others to achieve results, this plan uses a mixture of process, output and outcome objectives and measures. An on-going program of evaluation studies will be used to illustrate the ultimate outcomes of AHCPR's work.

AHCPR has aligned its goals with the three budget activities. The first five performance goals commit to results for the program activity of research performed on health costs, quality, and outcomes and support both of the above HHS strategic goals. The first four of these goals are structured to reflect the research cycle of needs assessment, knowledge creation, translation and dissemination, and evaluation.

In AHCPR has identified how it will use the findings of its needs assessment activities to implement Agency philosophy that research must begin and end with the user. It hast identified the expected results of research performed and due to be completed in FY 1999 which will add to the knowledge base of what works and at what cost. Another goal translates this knowledge into practice through the development and provision of information, products, and tools for use in operational settings. The agency will take an initial step to identify the outcomes of the AHCPR research and information that has been put into practice. AHCPR's performance is focused on providing leadership for improvement in the quality of health care.

The activities of the Medical Expenditures Panel Surveys program activity support the HHS strategic goal for health research enterprise and productivity. Because the purpose of MEPS is to collect detailed information regarding the use of and payment for health care services from a nationally representative sample of Americans, process and output indicators are appropriate to ensure that timely data is available.

The agency's plans for program support also support both HHS strategic goals and identifies improvements which will help AHCPR to increase its effectiveness in accomplishing the other performance goals.

Data Issues

The Agency's approach consists of capitalizing on data collection opportunities as a by-product of the work we do or sponsor, partnering with public and private organizations, and maximizing the use of information technology applications. AHCPR will use a variety of data collection methods including information gathered from research applications, the grants management information system, other information technology applications, the employee performance management system, partnerships with public and private sector organizations, evaluation studies, and customer surveys. Customer surveys are a critical source of information on the appropriateness, use, and quality of AHCPR products and services. The use of this approach is being expanded in the 2000 plan. AHCPR will use a variety of mechanisms to validate the information and data presented to describe what has been achieved for the indicators. A great deal of the information needed relates to the funding and results of research. The AHCPR financial and grants management computer systems automatically collect much of this information. Many Agency activities (e.g., tool development) have evaluation components built directly into the projects. The infrastructure for customer surveys is in place in some instances (e.g., the publications clearinghouse). The Agency currently is developing the rest of the necessary infrastructure. AHCPR will also undertake an evaluation studies to determine the impact of AHCPR-sponsored and conducted research on the health care system. Finally, as the results of the assessment activities are produced, the Agency will evaluate whether the right indicators are being used to measure its success.

Key Improvements to the FY 2000 Plan

- The number of measures have been reduced to 35 from 60 in FY 1999.
- Seventeen of the measures are outcome measures.

  The goals, objectives, and measures are now presented in tables.

  Strategies for each goal are included.

  The discussion of data collection issues has been expanded both in the Executive Summary and in the tables next to each measure.

  Examples of previous Agency successes for each goal are included before each table.

  An attachment that details the alignment of the AHCPR Performance Plan with the HHS Strategic Plan goals and objectives has been added.

Centers for Disease Control and Prevention

Overview

The Centers for Disease Control and Prevention (CDC) is the lead Federal agency that promotes health and quality of life of Americans by preventing and controlling disease, injury, and disability. To accomplish its mission, CDC collaborates with partners throughout the nation and the world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthy environments, and provide public leadership and training.

CDC exercises leadership in concert with other Federal, State and local agencies, tribal nations and private organizations. All of these partners contribute to the successful accomplishment of the HHS strategic goals, and in particular:

★ *Reduce the major threats to health and productivity of all Americans;*
★ *Improve public health systems; and*
★ *Strengthen the nation's health sciences research enterprise and enhance its productivity.*

Through its programs in Environmental Health, Infectious Disease, Occupational Safety and Health, Epidemic Services, and the Prevention Centers, CDC will continue to support the HHS strategic goal of strengthening the public health science base by conducting its own research and providing the funding for extramural research. CDC will also support the HHS strategic goal of improving public health systems by working with its partners at State and Local health departments and with non-governmental organizations at the community and national levels, to translate research into community action by designing, implementing, and evaluating sound prevention programs. CDC provided funding also will help State and Local health departments to build their capacity to reduce sexually transmitted diseases, HIV/AIDS, tuberculosis, vaccine preventable diseases, breast and cervical cancer, diabetes, injuries, and childhood lead poisoning.

In addition, CDC contributes to the HHS strategic goal of reducing major health and productivity threats by continuing to fulfill its unique role of providing timely, comprehensive information on current health issues and problems through the Health Statistics program. Health threats are also detected and assessed by CDC's Preventive Health and Health Services Block Grant, Epidemic Services, and Cancer Registries programs. Environmental health threats are addressed via a collaborative partnership among CDC, the Agency for Toxic Substances and Disease Registry, the Environmental Protection Agency, and the National Institute of Environmental Health Services.

Approach to Performance Measurement

CDC will assess performance for each of its program activities in an organized framework that addresses: program purpose, objectives, performance measures, partnership opportunities, and data collection methods. Assessment for each program activity will also address linkages with other programs and agencies, and support of the strategic goals of HHS and CDC.

Since these activities complement each other, the plan is organized into functional areas of infectious diseases, immunization, health statistics, chronic disease prevention, prevention research, preventive health and health grants, and injury prevention and control. The infectious disease function, for instance, includes several disease prevention programs: Emerging Infections, Tuberculosis, HIV/AIDS, and Sexually Transmitted Diseases.

Because data exist, outcome performance measures are identified for many of CDC's programs. A number of them are based on the Healthy People 2000 goals and objectives. CDC therefore identifies outcome measures for reducing diseases such as tuberculosis, HIV/AIDS, sexually transmitted diseases, and vaccine preventable diseases.

Where it is not possible to identify specific reduction targets and measures, CDC has included the rationale for output and process measures. Many of these output and process measures concentrate on CDC's efforts to help improve detection and prevention programs in State and Local health departments.

Data Issues

In order to effectively respond to a wide spectrum of health issues (including infectious diseases, chronic conditions, reproductive outcomes, environmental health, occupationally related health events, and injuries) CDC depends upon a broad array of data collection methods and systems. These systems are critical to the success of CDC as they provide the science base for CDC's programs. Through these systems, CDC is able to identify health problems, design interventions, and monitor program performance. Though many of the data systems were developed to support scientific objectives, they have become an important tool in performance monitoring. Nevertheless, several specific challenges in providing data to monitor performance under GPRA have been identified. They include:

- As GPRA measures are refined over time, data systems will need to produce data on a more timely basis, and with a frequency relevant to the periods over which performance is being measured.

- As the health system itself changes, it can no longer be assured that historical data series will continue to produce needed data. For example, the move toward managed care may make medical information increasingly proprietary, making access for research and statistical purposes more difficult. Similarly, changes in relationships between different health care providers, as well as laboratories, may make public health surveillance based on case reports more difficult. At the same time, these changes present opportunities for new partnerships to obtain needed information.

- Data systems will need to produce information in sufficient quality and precision to detect what may be relatively small changes in key performance indicators. This may require investments in larger sample sizes for surveys, new technology for improving data quality, and so forth. Continuing research will be required to establish the data systems, as well as the underlying evaluation approaches, for assessing cause (program intervention) and effect (outcomes) for performance monitoring.

- Many current major national data systems are the source of GPRA measures for CDC and for other health programs. However, nearly all are endangered due to chronic resource limitations.

- Many CDC and HHS programs are implemented at the State and Local level, and it will be increasingly important to obtain reliable, systematic data at these levels to monitor program implementation, performance, and outcomes.

At least seven categories of information are used by CDC and its partners to understand and address disease, injury, and disability using the public health model. These categories of information include:

Reports of Health Events
Vital Statistics
Information on Health Status, Risk Factors, and Experiences of Populations
Information on Potential Exposure to Environmental Agents
Information on Programs
Information from Other Organizations
Information on the Heath Care System

CDC's Performance Plan Executive Summary contains examples of representative systems for each of these information categories. Additionally, strengths and limitations associated with each representative system are provided.

In addition to the traditional data collection systems described above, CDC's performance plan relies upon other a number of other less traditional data sources. These sources include:

Data from States funded by CDC
On-site technical assistance visits
Contractor reports, published data, studies, and recommendations
CDC's WONDER tracking system, which is able to track the number of Internet "hits"
Reviews of annual reports, policy documents, and profiles

The frequency of data collection varies between programs. For example, some proposed measures rely upon on-going quarterly report data, while others may represent annual collection efforts.

Verification and validation of performance is discussed for each program activity. Since much of the performance data is obtained from States, grantees, and contractors, there will be a mix of site visits, progress reviews, and publication reviews to verify the data.

Key Improvements to the FY 2000 Plan

The CDC FY 2000 Performance Plan has integrated significant improvements over the FY 1999 Performance Plan. These improvements can be categorized as two general types: contextual and process. Contextual improvements in the FY 2000 plan relate to the written plan (content, format, and performance measurement quality.) Process improvements are business practices that have changed to facilitate implementation of the CDC performance management system.

Contextual Improvements

- For the FY 2000 Performance Plan, CDC programs have made significant progress in developing more outcome-oriented performance measures. Whereas many of the established programs such as Immunizations and Sexually Transmitted Diseases had excellent outcome measures for the FY 1999 Performance Plan, two of CDC's newer program areas (Chronic Diseases and Injury Prevention and Control) have replaced process measures with outcome measures. CDC continues to rely on process and capacity measures for many of its programs. For those programs, CDC clearly links the achievement of capacity and process to the longer-term, desired outcomes. For example, the Emerging Infections Program provides a logic model to illustrate the need to build capacity within state and local health departments. Achievement of this capacity will enable state health departments to address the unique nature of emerging diseases.

- The FY 2000 Performance Plan contained approximately 40 performance goals. The FY 2000 Performance Plan contains more than 50 performance goals. In some instances, additional goals were added by programs to better represent the broad, diverse, and numerous programs supported, such as the case with the Infectious Disease Program. CDC has also included proposed program goals for each new budget initiative (Eliminating Health Disparities and Public Health Response to Terrorism.) The FY 2000 Performance plan also includes specific performance measures in the Office of the Director that are key to support CDC programs. CDC managers continue to stress limiting the number of goals and measures to the critical few, but maximizing the ability to communicate program direction, assess success and identify areas needing improvement.

- In aligning the FY 2000 Performance Plan goals and measures with those in the FY 1999 plan, CDC program staff recognized the need to select goals and measures that could be assessed by reliable and consistent data sources. In situations where the data sources were not as reliable as was deemed appropriate, CDC programs modified their goals and measures for FY 2000 to reflect the stronger data sources. The Injury Prevention and Control Program is one such example where FT 1999 data was based on data sources from another federal agency (Department of Transportation (DOT)). DOT data were obtained from random surveys of 19 state sites. The random nature of the survey limits the usefulness and consistency of the data. This data limitation caused the program to redefine the goal and associated performance measures, and to base them on more reliable data sources.

- To sustain the performance of many of CDC programs, a core public health infrastructure must be maintained at a consistent level of performance. The FY 2000 Performance Plan includes explanations and support for the maintenance of performance levels that are constant across performance years. The Immunization Program and the Sexually Transmitted Disease Program are two examples where the performance levels remain constant across FYs 1999 and 2000. Even though levels of performance do not change, it is important to assess these measures each year to monitor and assure effective program performance.

- In the FY 2000 Performance Plan, CDC provided improved explanations for key programs regarding baselines, targets, and reasons for modifications are documented in footnotes.

- The format for the FY 2000 Performance Plan contains tables listing the performance measures and baselines for FY 1999 and FY 2000 throughout the document. The format changes improves the ability to visualize and compare the annual targets and performance for each program area.

Process Improvements

- The significant transformation in the process of planning and developing the FY 2000 Performance Plan is notable. The extent of internal and external collaboration and coordination was greater for the development of the FY 2000 Plan. In planning for the FY 2000 plan submission, internal collaboration among the planning, financial management, information resources and CIO staffs was well coordinated. This improved coordination reduced duplication of effort and led to more informed decision making. External collaboration in the development of performance goals and measures also increased, resulting in more consistent measures across agencies as well as with national objectives such as Healthy People 2000/2010.

- The FY 2000 performance planning process integrated both GPRA and Chief Financial Officer Act (CFO) requirements, reducing the redundancy of implementing the common elements of each Act. A steering committee has been formed at CDC to guide the development of a management information system to incorporate cost accounting and program management functions for CDC staff to efficiently and effectively implement GPRA and CFO.

- By providing a clear plan for new initiatives, including performance goals and measures, CDC developed a more focused approach to addressing new initiatives — as well as more focused new initiative proposals. Overall, the agency has improved coordination and collaboration in all areas of planning.

Food and Drug Administration

Overview

The programs of the Food and Drug Administration (FDA) protect and promote the health and safety of the American people by the regulation of foods, cosmetics, human and animal drugs, animal feed, tobacco, and biological products and devices used for medical purposes. The role of FDA is prominent in the five following HHS strategic plan objectives:

- ★ *Assure food and drug safety by increasing the effectiveness of science based regulation;*
- ★ *Accelerate private-sector development of new drugs, biologics, therapies, and medical technology;*
- ★ *Reduce tobacco use, especially among youth;*
- ★ *Improve the diet and level of physical activity of Americans; and*
- ★ *Promote the appropriate use of effective health services.*

FDA must carry out its protection and promotion role in an environment characterized by explosive growth and complexity. The products the agency regulates have become increasingly sophisticated and require great depths of scientific understanding to foster sound regulatory decisions. The number of adverse events associated with these products has grown in parallel to their increasing availability and complexity. In the international arena the volume of imports grows at an increasing rate, and regulation of these products requires intense and delicate negotiations in the global arena.

To respond to these changes, FDA is relying to a greater extent on its many stake holders in the public and private sector to understand the nature and scope of the regulatory challenges it must address; and to formulate cost-effective solutions to those challenges. For new medical products, the Agency is consulting with product sponsor in the early stages of drug, biologics and medical device development in order to accelerate the product's movement through FDA's review process. FDA also interacts with the broader scientific community to ensure that review decisions are based on rigorous and appropriate scientific conclusions.

In the import arena, FDA has partnered with the customs service to develop a screening system which allows for rapid entry of safe products into this country, and prevents hazardous products from crossing our borders. To minimize risk associated with food consumption, FDA is collaborating with USDA, CDC and EPA in a national food safety initiative, which emphasizes rapid response to and resolution of food safety problems, bolstered by strong research, surveillance, compliance and education capabilities.

Recently, FDA has also had to address the rapidly changing regulatory environment for tobacco, which will require FDA to operate in concert with other HHS Operating Divisions (CDC, SAMHSA, and HRSA), other Federal agencies and the States. FDA will continue to develop its performance planning to include joint performance goals with its partners.

Approach to Performance Measurement

Due to the many other parties that are involved in the production, sale and consumption of the Nation's food, drugs, and medical products, it is obvious that FDA's actions alone cannot ensure the safety of these products. FDA's approach to its performance plan has been to include performance goals and measures that address the entire food and drug continuum. There are measures for the actions that FDA takes in the execution of its programs (process), the results of its regulatory actions (output), as well as some outcome measures. FDA has numerous goals that address its review time for food, new drugs, biological products and medical devices; and its efforts to ensure that manufacturing establishments for these products conform to FDA standards. There are some outcome measures such as the usage of food labels in making nutritious food and reduction in risky food handling and consumption practices. In addition, FDA also included measures for the underlying processes and research that support these efforts. FDA adopted the spirit of the Results Act and extensively involved program managers, who have the most detailed knowledge, in the development of its goals and measures.

Data Issues

FDA recognizes that the safety and effectiveness of foods, drugs, and medical products (outcomes) are the primary concern of the American taxpayer. The development of additional outcome measures has been a challenge for FDA as it does not yet have extensive processes and systems in place to measure and evaluate many outcomes. With greater emphasis on outcomes and with the establishment of more external partnerships to achieve those outcomes, FDA, other Federal agencies, and industry partners will depend upon one another to generate useful outcome measures.

FDA uses a combination of existing and newly designed data bases to assess progress in achieving its goals. Many databases are collaborative efforts with other Federal and States agencies and with consumer and industry groups. Some are exclusive to FDA. In 1998, FDA initiated a verification and validation system to help program managers monitor progress toward achieving FDA's goals. This system will include training to learn essential aspects of performance measurement, a checklist for verifying and validating goals, and assistance in applying performance data in reporting and management.

Key Improvements to the FY 2000 Plan

The FY 2000 performance plan reflects the end of the second cycle of planning under the requirements of GPRA. FDA has made great improvements in its second year of performance planning. Some improvements stem from better coverage of Agency programs by performance goals, and others are a result of improvements in FY 1999 performance goals and measures. The agency is learning about performance measurement, and is more closely linking performance to budget decisions. FDA has emphasized its statutory requirements in the FY 2000 performance plan, as required by the Food and Drug Administration Modernization Act of 1997 (FDAMA).

During the FY 2000 planning cycle, senior management was also more closely involved in the performance measurement process. This was spurred on by leadership that was more focused on future

directions in an FDA-wide, corporate sense, and by the FDAMA legislation that focused the Agency on measuring how, in performance terms, FDA is progressing toward meeting statutory requirements. To highlight this strategic thinking, the plan for FY 2000 is organized under the program areas by outcome-oriented strategic goals. Each strategic goal is supported by a set of balanced performance goals to measure accomplishment toward the strategic goal.

Key improvements to FDA's FY 2000 plan include:

- Improvement of existing performance goals by better defining measures or developing more stable baselines;
- Development of performance goals in areas not previously covered;
- Better linkage of strategic and performance goals;
- Increased understanding and use of performance measurement throughout the Agency;
- Planning process more oriented toward budget preparation and strategic management decisions; and
- More through narrative explanations of Programs.

Some data upon which performance measures are built are not yet available, and in many such cases, partnerships with other agencies are being built to collect and share information. For example, in the food safety area, public health data systems are not adequate to provide accurate and comprehensive baseline data needed to draw direct relationships between FDA's regulatory activities and changes in the number and types of food borne illnesses that occur annually. FDA and USDA began working with CDC in 1995 to improve food safety surveillance. FoodNet, an active surveillance program, was created through this joint effort. In 2002, the data will be sufficient in volume and quality to establish baselines against which to measure changes in food borne illnesses. In the veterinary medicine area, FDA was fully involved in the design and development of the FDA/USDA Residue Violation Information System, and FDA is working closely with CDC's Office on Smoking and Health, SAMHSA and the Data Council of HHS to devise and conduct surveys to measure success in reducing initiation and use of tobacco by young people.

For better data on its accomplishments in the safety of product manufacture and compliance with FDA regulations, FDA is developing a system that will consolidate over twenty separate Field data systems, called the Field Accomplishments and Compliance Tracking System (FACTS). The system includes five major postmarket areas: management of firms, compliance, investigative operations, laboratory operations, and other operations that include consumer feedback. Implementation of the FACTS system to the FDA Regions will occur throughout FY 1999, with FY 2000 being the first full operational year.

Health Care Financing Administration

Overview

Through the administration and management of Medicare, Medicaid, and other programs, the Health Care Financing Administration (HCFA) and its partners carry out the Agency's fundamental mission – to "...***assure health care security for beneficiaries***." Under basic program authority, HCFA pays Medicare benefits through private fiscal agents; provides States with matching funds for Medicaid benefits; conducts research, demonstrations, and oversight to ensure the safety of facilities and quality of medical services provided to Medicare beneficiaries; and establishes rules for eligibility and benefit payments. These programs finance and ensure access to health care for elderly, disabled, and low-income persons. HCFA has become the largest purchaser of health care in the United States, serving approximately 77 million Medicare and Medicaid beneficiaries and their families in FY 1998.

Over time, HCFA's statutory mission has grown beyond administration of Medicare and Medicaid to include responsibility for Federal oversight of clinical laboratories under the Clinical Laboratory Improvement Amendments and, under the Health Insurance Portability and Accountability Act, for individual and small group health insurance regulation.

The Balanced Budget Act (BBA) of 1997 made the most sweeping changes in HCFA's programs since 1965. This legislation, which contains over 300 provisions, requires HCFA to develop and implement new payment systems for many Medicare services to improve payment accuracy and help further restrain the growth of health care spending. The BBA also creates an array of new managed care and other health plan choices for Medicare beneficiaries; establishes a Medicare open enrollment process coordinated by HCFA; authorizes a demonstration of Medical Savings Accounts for up to 390,000 Medicare beneficiaries; and established the State Children's Health Insurance Program to build on the Medicaid program. These new elements of the Medicare program, as well as additional significant provisions related to the Medicaid program, have brought significant and challenging new work to HCFA.

HCFA, State Medicaid Agencies, Medicare fiscal agents, and health-care providers who serve HCFA's beneficiaries are partners in the successful attainment of four HHS strategic goals, but particularly of the HHS goals to:

★ *Improve access to health services and assure integrity of the nation's health and entitlement safety net programs; and*

★ *Improve the quality of health care and human services.*

The Medicare and Medicaid programs administered by HCFA, in partnership with the States and the health care industry nationwide, are the two most significant mechanisms for ensuring access to quality care for the elderly, disabled, and low-income populations. Through these programs and their projected outlays in FY 1999 of $347 billion, an estimated 72 million Americans will have access to high quality health care.

The performance goals and indicators of HCFA are also consistent with the Department's commitment to identify and resolve significant management challenges through GPRA, particularly in its efforts to eliminate fraud, abuse, and waste in Medicare and Medicaid. HCFA addresses this major HHS management challenge and high-risk area with definitive goals and measures to reduce fraud, particularly in the vulnerable home-health sector, to reduce improper payments, and to increase electronic transactions that are less prone to problems.

Approach to Performance Measurement

HCFA's performance plan consists of a manageable set of performance goals and measures that is consistent with strategies recommended by OMB and GAO for measuring program performance. Two principles characterize HCFA's approach to performance measurement. The first principle, which links HCFA's plan to the HHS and HCFA strategic goals, is: ***"The most important things to measure relate to ensuring that Medicare and Medicaid beneficiaries receive the high quality care they need."*** The second fundamental principle which guides HCFA's plan is: "*HCFA will pursue performance goals that are representative of program performance."*

Central to performance measurement for HCFA is the beneficiary focus that is integral to its strategic goals and objectives. To move toward the accomplishment of HHS's goals and HCFA's own strategic goals and objectives, HCFA has identified 30 performance goals for FY 2000 which include a mix of outcome, output, and process goals, although all of its performance goals are closely tied to program outcomes. The result of this approach is that HCFA's performance goals are grouped into three "levels": (1) core beneficiary goals, (2) beneficiary-related goals, and (3) administrative output goals. Core beneficiary goals and beneficiary-related goals are the most clearly outcome oriented while the administrative output goals have aspects of output, process, and outcome goals. This approach to performance measurement provides comprehensive program coverage.

The most outcome-oriented measures are the core beneficiary goals related to quality of care, access to care, and beneficiary satisfaction with care and service. For example, measurement of beneficiaries' receipt of influenza vaccines and mammogram are both direct measures of HCFA quality efforts, but also are considered supplemental proxy measures of beneficiary access to care. The "beneficiary-related" goals (e.g., health plan choice) are linked to outcomes important to beneficiaries and directly observable by beneficiaries.

HCFA's "administrative output" goals include both output and process measures. Many of these administrative goals have the flavor of outcome measures as well. HCFA's performance goal related to the rate of error in fee-for-service payments is, for example, closely related to the outcome of wise management of taxpayer monies and beneficiary confidence in the program. HCFA's performance goal with respect to the millennium transition is both a "process" measure and an "outcome" measure because paying for medical care reliably, accurately, and on time is an important result of HCFA activity, in addition to the core mission of ensuring access to high quality health care for beneficiaries.

A key concept underpinning the GPRA law is the close linkage between an agency's strategic plan, performance plan, and its budget. While HCFA's performance plan reflects both its Agency-level strategic goals and objectives and pertinent goals in the HHS Strategic Plan, HCFA has also taken care

to ensure that major budget categories, including both program benefits and program administration funds, have adequate coverage in the Annual Performance Plan.

Data Issues

Most of the data systems used to evaluate HCFA's performance on its GPRA goals are sufficiently reliable to provide accurate reporting. Most of the data for measuring performance goals are from pre-existing HCFA internal data systems. While many of the data sources already exist or were far along in the planning process, HCFA will need to design a data collection system for some of the new performance goals (such as the telephone customer service goal).

To overcome potential threats to the validity and reliability of data sources, comparisons across similar data systems will be conducted where practical. For the administrative data systems, the reliability and validity of all data is enhanced through an editing process designed to validate accuracy and reasonableness. To the extent possible, all data systems used for reporting on the progress of performance goals will be examined for consistency. Also, standard programs and edits will be used on all databases to check for data anomalies.

In addition to data already available through HCFA systems, HCFA uses survey data or evaluations/special studies conducted by other Federal agencies. For example, HCFA relies on surveys conducted by the National Center for Health Statistics and audits conducted by the HHS Office of Inspector General, among others. Utilizing outside data sources allows HCFA to collaborate with these other entities in performance measurement and to conserve resources by minimizing duplication of efforts.

Key Improvements to the FY 2000 Plan

In HCFA's FY 2000 plan, the total number of goals (30) remains manageable, yet the goals provide better coverage of major program areas and budget categories than did the 22 goals in the Agency's FY 1999 plan. Enhancements to coverage were achieved by adding new goals not contained in the FY 1999 plan.

In addition to enhancing coverage by adding or expanding performance goals, HCFA responded to comments on its FY 1999 plan by adding more detail to descriptions of coordination with other organizations to reflect the full extent of joint efforts with other organizations inside and outside of government. HCFA has also enhanced discussions of data limitations, as well as data validation and verification, relative to its FY 1999 plan. As summarized above, HCFA has been careful to cite and describe data sources for each individual goal, as well as particular data concerns or limitations.

Another key improvement this year was in the goal development process within HCFA, which was more participatory throughout HCFA's Centers and Offices. This approach helped to strengthen the plan in certain areas and to ensure that the goals reflect Agency priorities and are fully supported by managers and staff at all levels. Areas in which this broader participation yielded a stronger plan include: Medicare+Choice implementation, program integrity, Medicare contractor functions, information technology, and quality of care/Peer Review Organizations.

Medicaid

For the FY 1999 Annual Performance Plan, HCFA requested, and OMB granted, a one-year waiver of GPRA rules for the Medicaid program to allow time for the Agency to continue a consultation process with State Medicaid officials aimed at producing performance goals of mutual interest. The FY 2000 plan includes a new Medicaid goal developed jointly with the States which commits HCFA and the States to increase childhood immunization rates over the next several years.

There are a number of other Medicaid-related goals included in this Annual Performance Plan carried over from the FY 1999 plan in consultation with Medicaid State Directors. These goals commit HCFA and the States to:

- Continue to reduce the use of physical restraints in nursing homes;
- Continue linking Medicare and Medicaid information with respect to dually eligible beneficiaries;
- Decrease the number of uninsured children by increasing enrollment in Medicaid and the State Children's Health Insurance Program;
- Sustain improvements in clinical laboratory testing accuracy; and
- Improve access to care for low-income elderly and disabled persons.

In addition, HCFA has added an FY 2000 goal tied to the Agency's nursing home initiative. Specifically, HCFA has committed to reduce the prevalence of pressure ulcers (bedsores) in nursing homes. HCFA plans to discuss this new goal with the States at the next State Medicaid Directors meeting.

The set of Medicaid goals represented here – the continuation goals plus the new childhood immunization and pressure ulcer goals – is an important next step toward complete coverage of Medicaid in the performance plan. As the collaboration with the States proceeds, we expect to add goals in other areas of mutual concern in future Annual Performance Plans.

Health Resources and Services Administration

Overview

The Health Resources and Services Administration (HRSA) operates to improve the Nation's health by assuring equitable access to comprehensive, quality health care. Fifty million or more Americans face serious barriers to receiving care. Forty-three million have no health insurance. Others qualify for Medicaid, Medicare or private insurance, but whether they live in a city or in a rural setting, have limited access to a doctor, nurse or other primary care provider. Others have HIV/AIDS or another health condition that makes basic health care more critical, but less accessible.

HRSA operates programs that contribute to and support several Department strategic goals. To improve access to health services, the HRSA-supported network of primary care health centers will increase the number of persons receiving primary care services--preventing disease and treating illness--in underserved areas. Through the Maternal and Child Health Block Grant, HRSA and States will increase the percent of pregnant women receiving prenatal care beginning in the first trimester and reduce the infant mortality rate. The Ryan White CARE Act programs will increase the number of people served, with a special emphasis on women, people of color and youth. HRSA also funds a variety of community-based programs to train the next generation of physicians, nurses and other health professionals and has objectives to increase both the percent of minority and disadvantaged graduates and the overall number of health care workers serving in underserved areas.

A major source of the Agency's strength is in the linkages and partnerships it has formed with a variety of Federal and external partners. Collaboration will continue to be HRSA's way of doing business. HRSA and the Health Care Financing Administration are jointly implementing the Children's Health Initiative, with particular focus on the new State Children's Health Insurance Program. With the Centers for Disease Control and Prevention, partnership activities are focused on a variety of disease prevention and health promotion activities, including immunization efforts and improved data collection and analysis. HRSA works with the Substance Abuse and Mental Health Services Administration on linking primary care services with services related to substance abuse, particularly given the close linkage between substance abuse and high rates of HIV infection.

HRSA distributes the majority of its funds through grant programs (categorical and block) and is pursuing partnerships with a variety of grantees and other external organizations such as State and local governments, non-profit health organizations, academic institutions, foundations, national associations, and business groups. Substantial work has been done to establish working relationships and agreements with such outside organizations. HRSA will continue to partner with State, local and non-profit organizations on ways to assure that programs are designed to meet the needs of the underserved. Work with States and communities forms the foundation for developing integrated service systems and the appropriate health workforce to help assure access to essential high-quality health care. The agency will need to leverage existing resources, work more creatively with established partners, and plan closely with new partners at all levels to assure the highest degree of coverage possible for the populations-at-need.

Approach to Performance Measurement

HRSA has made a strong effort to build a performance management approach into the way it conducts its business. The agency has gone through an internal strategic planning process and has used a preliminary set of goals to guide the development of its Annual Performance Plan. The goals focus on:

- Access to comprehensive, timely, culturally competent and appropriate health care services for all underserved, vulnerable and special needs populations.

- Disparities in health status and health outcomes for underserved, vulnerable and special needs populations.

- Quality care provided to the underserved, emphasizing a diverse, quality work force and the use of emerging technologies.

Performance measurement capabilities currently vary among the agency's six major components and 50 programs. Consequently, HRSA's performance plan contains a mix of process, output and outcome goals and indicators focusing on programs' internal activities (e.g., training approach used), direct products or services (e.g., number of people provided health services, number of people trained), and the results of program output (e.g., changes in health status, mortality or morbidity).

Data Issues

There are numerous issues about the availability, burden and cost of data to measure performance and results.

- HRSA has several efforts underway to increase the use of common, structured and standardized data strategies to carry out performance measurement

- The issue of competing needs to collect essential performance measurement information while meeting the requirements of the Paperwork Reduction Act that must be addressed.

- Resources, in terms of funding and staff with data collection and analytical skills, continue to be in limited supply.

Key Improvements to the FY 2000 Plan

HRSA has made a number of improvements in the Revised Final FY 1999 and FY 2000 version of its Annual Performance Plans.

Improved Linkage to Strategic Plans. Since the final Strategic Plan of the Department of Health and Human Services was submitted to the Congress on September 30, 1997, HRSA has been better able to link its performance goals with the goals and objectives in that Strategic Plan. For each of the six HHS goals, HRSA has provided examples of program activity and Revised FY 1999 and FY 2000

performance goals. A matrix is included in the Executive Summary which provides examples of this linkage.

During the past year, HRSA has also developed a draft of its own Strategic Plan. The agency is continuing to receive input as to the structure and specificity of the objectives. The Performance Plan makes reference to the proposed HRSA goals and objectives, in order to provide a linkage to the HRSA Strategic Plan.

Continued Improvement in Data Sources and Information. The agency has made a concerted effort to strengthen the level of data sources and information used to measure performance goals. This is an area that will require continuous attention. A discussion of Data Issues is included in the Executive Summary which provides additional information on the data sources that are being utilized and progress made in improving data systems.

Streamlined and Consolidated Performance Goals. HRSA has substantially streamlined and consolidated the number of performance goals. The original FY 1999 Performance Plan had approximately 150 goals. The Revised Final FY 1999 and FY 2000 Performance Plan has some 86 goals. As the agency approaches development of the FY 2001 budget, it is expected that the number of goals will continue to be streamlined and consolidated.

This approach is reflected in the new approach used by the Bureau of Health Professions. Last year, individual performance plans were developed for each of some 26 health professions and nursing training programs. For Revised FY 1999 and FY 2000, the performance plans for these programs have been integrated into one plan which is presented in terms of seven cross-cutting indicators. It focuses, for example, on the effect of all health professions programs on increasing diversity by increasing the number of minority/disadvantaged graduates and enrollees.

Focus on Evaluation. HRSA has included a discussion of how the evaluation program supports performance planning. This includes both efforts to utilize technical assistance and training to strengthen the Agency's capacity to assess program performance, and through individual studies to complement the data developed through monitoring systems related to GPRA. A discussion of the Evaluation Program is included in the Executive Summary.

Additional Performance Plans this Year. HRSA has added performance plans for six areas not included in the original FY 1999 Plan: Nursing Loan Repayment, Children's Hospitals Graduate Medical Education, Rural Hospital Flexibility Grants, Telehealth, Family Planning, and Program Management.

Indian Health Service

Overview

The Indian Health Service (IHS) administers the principal health program for American Indians and Alaska Natives (AI/AN) by providing comprehensive prevention and treatment health services through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs. Improving the health status of American Indian and Alaska Native people is the essence of the IHS mission and is supported by four broad strategic objectives in the HHS strategic plan. In addition, IHS is committed to supporting tribal self-determination and local capacity development through collaborative partnerships with I/T/U programs.

The I/T/U system provides health services to 1.49 million AI/AN people. The range of services includes inpatient and ambulatory care, and extensive preventive care, including focused efforts toward health promotion and disease prevention. Tribes who have elected to retain the Federal administration of their heath services, or to defer tribal assumption of IHS programs until a later time, receive 58 percent of the IHS funded services. Indian tribes deliver 42 percent of the IHS funded services to their own communities. Since FY 1993 there has been a significant transition to tribal management of health programs under Title I and III of the Self-Determination legislation. In addition, a variety of health care and referral services are provided to Indian people away from the reservation settings through 34 urban Indian health programs which are funded from a separate line item in the IHS budget. Another integral part of providing care to the AI/AN population is the purchase of services from non-IHS providers to support, or in some cases in lieu of, direct care services. Contract health services, composed of both IHS and tribal components, represent about 18 percent of the IHS budget and is distributed to IHS and Tribal programs at the same relative percentage as direct services funding.

The IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the AI/AN people. This contention is supported by dramatic improvements in mortality rates between 1972-74 and 1992-94, including: maternal mortality reduced 86%; tuberculosis mortality reduced 78%; gastrointestinal disease mortality reduced 77%; infant mortality reduced 61%; accident mortality reduced 56%; and pneumonia and influenza mortality reduced 48%.

The IHS achieved these improved outcomes despite a history of significantly lower per capita health care funding than the country as a whole. However, funding has been less favorable in recent years because of the balanced budget initiatives and has resulted in a loss of per capita funding for services that is now estimated at almost a 20 percent loss of spending power. Consequently, while overall outpatient visits have steadily increased with the population growth (about 2.1 percent growth annually), decreases have occurred in important non-urgent primary services. Thus, the increasing demand for urgent care in the face of reduced per capita funding has reduced the capacity of the IHS to provide the primary services that are critical to long-term health maintenance and improvement. Of greatest concern, the most recent mortality data (FY 1994) available from the National Center for Health Statistics show an upward trend in deaths of AI/AN people since FY 1992 from cancer, diabetes, heart disease, suicide, alcohol, drugs, HIV/AIDS, and tuberculosis.

Approach to Performance Measurement

This combined IHS FY 1999 and FY 2000 Annual Performance Plan and its performance indicators were developed in partnership with critical stakeholders including IHS Headquarters, Area Office, and I/T/U staff as well as elected tribal representatives. For the FY 2000 process, regional meetings were held to outline the GPRA and budget formulation process for all IHS Area Formulation Teams. These Area teams then provided local I/T/U programs the opportunity for input and review of the Area recommendations, which were then compiled. In May, 1998 Area Formulation Team representatives came together in Rockville, MD along with representatives from several Indian organizations and tribal leaders to merge and reconcile the Area recommendations into a single IHS set of budget priorities. This process was led and facilitated by tribal leaders with the IHS participants serving as staff support.

Using these priorities, a concurrent workgroup began reviewing the appropriateness of the FY 1999 indicators given that the health priorities had changed little. The plan has now been built upon ongoing IHS efforts to adapt the existing IHS data system to the Joint Commission for Accreditation of Healthcare Organization (JCAHO) data requirements for accreditation and the recommendations of the Baseline Measures Workgroup. The Baseline Measures Workgroup was a group of IHS and tribal health professionals, including epidemiologists and statisticians, charged with identifying the most important health related data elements for all I/T/Us to continuously or periodically monitor. Their efforts included extensive analyses of existing data sources, the appropriateness of the ***Healthy People 2000*** (HP 2000) objectives, and the data needs for evaluation and accreditation. To reduce total data collection requirements at the local level, the IHS is developing the capacity to monitor some of the JCAHO data elements known as ORYX as part of existing patient care data systems. The IHS will also use this capacity to monitor a number of GPRA performance indicators.

The IHS performance indicators identified represent sentinel indicators which are specifically focused on the most significant health problems (i.e., as identified by the I/T/Us and the Baseline Measures Workgroup) affecting AI/ANs, and/or the essential services that address them. These problems include: diabetes, alcohol and substance abuse, cancer, dental diseases, mental health, heart disease, family abuse and violence, injuries, poor living environment, mental health, tobacco use, obesity, environmental hazards, and the unique health problems of elders, women and children. They all represent important links in the GPRA/Public Health process directed towards outcomes. Some represent primary prevention that attempts to prevent a disease or condition before it has occurred (e.g., immunizations or controlling weight to prevent heart disease or diabetes). Others are "secondary preventive" in nature in that they attempt to reduce the morbidity and mortality associated with a disease or condition after it has occurred (e.g., reducing diabetic complications or breast cancer screening). Given that there will always be ten leading causes of death, our focus is to intervene early in the processes that contribute significantly to mortality and morbidity, rather than to target end point problems such as heart attacks and stroke. This is the essence of the public health approach that has resulted in the improvements in health status of AI/AN people in the face of a low per capita expenditure for health care over the last three decades.

Data Issues

IHS utilizes outside (non-IHS) and IHS data sources to manage its diverse programs and assess Indian health status. The two principal outside data sources are the Bureau of the Census and the Centers for Disease Control and Prevention, in particular, the National Center for Health Statistics (NCHS). The Census Bureau is the source of Indian population counts and social and economic data. However, reliable Indian census data at the county level are only available from the decennial census, every 10 years. The NCHS provides IHS with natality and mortality files that contain all births and deaths for U. S. residents, including those identified as American Indian or Alaska Native. The data are subject to the degree of accuracy of reporting by the States to NCHS. The NCHS does perform numerous edit checks and imputes values for non-responses. Several studies have shown that there is considerable miscoding of Indian race on death certificates that understates Indian mortality especially in areas not associated with Indian reservations. While the IHS has developed some techniques for adjusting for miscoding, the chief limitations of mortality data are associated with time lags, i.e., the data are not typically available from NCHS until three years after the events occur and mortality data are slow in showing the impact of health interventions.

The IHS has its own program information systems to collect data on the services provided by IHS and tribal direct and contract programs. Data are collected for each inpatient discharge, ambulatory medical visit, and dental visit (all patient specific) and for community health service programs including health education, community health representatives, environmental health, nutrition, public health nursing, mental health and social services, and substance abuse. These data are subject to recording, inputting, and transmitting errors. However, IHS software systems have extensive edits built in at the facility and central database levels to detect and correct a large part of the errors. Others that cannot be detected by computer are often discovered through the monitoring for reasonableness that is performed in the field and IHS headquarters. Many of IHS proposed measures rely on detailed data not currently transmitted to the IHS central database. IHS is developing software to transmit some of these needed data items to the central database. In the meantime, IHS will need to use sampling routines to collect the required data from the individual facility-level databases.

The iterative process of developing the FY 1999 and FY 2000 performance plans has required IHS to audit many different data sets to assess current access to health services (coverage) and baseline rates of various conditions. During this process it has become increasingly clear that the continued diversion of available resources toward maintaining patient care in response to recent funding shortfalls, has resulted in a significant loss of the public health infrastructure that support data collection and analyses. Data sets that were previously well enumerated and maintained are now incomplete or under analyzed. In light of these findings, IHS has revised several indicators for FY 1999 to focus on assuring data capturing capabilities and securing baselines to support FY 2000 indicators that address restoring or enhancing services.

Key Improvements to the FY 2000 Plan

IHS has expanded its already substantive executive summary with an extensive discussion of program evaluations and performance measurement at IHS. This discussion begins with IHS' commitment to involve American Indians and Alaska Natives as the primary stakeholders in defining the purpose,

design and execution of IHS' evaluations. It covers IHS' evaluation strategy, general types of evaluations conducted, and changes taking place inside and outside government that will affect the IHS evaluation strategy in the coming years. In addition, IHS summarizes six recent evaluation activities that have significant direct and/or indirect implications for IHS performance planning.

The IHS has also added a "Linkages" section in the description of each performance indicator which identifies how the indicator relates to the FY 1999 IHS Performance Plan, the Secretary's FY 2000 Initiatives, the HHS Strategic Plan, Healthy People 2000 Objectives, and collaborations with other agencies.

National Institutes of Health

Overview

The programs and activities of the National Institutes of Health (NIH) are central to the mission of HHS to foster sustained advances in the sciences underlying medicine and public health. Through its mission to sponsor and conduct research that leads to better health for all Americans, NIH supports its own strategic framework and HHS's strategic goals to strengthen the nation's health research enterprise, reduce threats to the health of Americans and improve public health systems. In line with the need to focus performance on the achievement of advances in science, NIH has determined that performance goals with a mix of quantitative and descriptive indicators provide the most meaningful and appropriate basis for GPRA assessments of the agency's programs.

Approach to Performance Measurement

Due to the cross-cutting nature of disease and scientific discovery, NIH aggregates its activities for performance measurement purposes into three core Programs: Research, Research Training and Career Development Program, and Facilities. The *Research Program* includes all aspects of the medical research continuum, including basic and disease-oriented research; observational and population-based research; behavioral research; and clinical research, including research to understand both health and disease states, to move laboratory findings into medical applications, to assess new treatments or compare different treatment approaches; and health services research. The *Research Training and Career Development Program* addresses the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for graduate training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the nation's health. The *Facilities Program* focuses on ensuring that the nation's scientists have adequate facilities in which to conduct their work.

Most of the more than 50 performance goals in NIH's FY 2000 Annual Performance Plan have objective/quantitative targets. For these goals, assessment is essentially a self-measuring process. While the specifics vary by the goal and program, in most cases the data provided in the performance report will allow a direct comparison between the performance target and the actual performance level.

NIH's performance goals for research outcomes are the chief exception to this approach. Agency missions directed primarily at advancing basic science face unique challenges in using only the objective/quantitative performance goals preferred under GPRA. It is neither feasible nor sufficient to capture the breadth and impact of such research outcomes through entirely numeric goals and measures. Quantitative assessment alone cannot adequately portray the effectiveness of the performance of NIH's research program.

Conventional scientific research metrics (e.g., publications, citations and patents) gauge only some dimensions of research output. These measures provide relevant data, but they are insufficient for generating a full picture of a research program's contribution. As the President's Office of Science and Technology Policy and numerous others who have studied the processes of science, technology, and innovation over many years have commented, the linkages between inputs and outputs in science are

complex and non-linear. Outcomes are usually very difficult to foresee with any degree of accuracy. The full value of any given research finding is usually only barely visible at the time of discovery, and reaches a state of fruition often only after many years or in combination with other advances. Furthermore, the downstream impact of basic research is usually dependent on substantial further development of new knowledge by private industry, other public sector researchers, or other economic actors.

Accordingly, descriptive data will provide much of the basis for assessment of NIH's Research Program. Narrative descriptions of research accomplishments will outline a specific research advance within the context of what was previously known and unknown about the topic; the scientific and/or medical significance of the research area and the accomplishment; the research that will follow from the finding; potential applications of knowledge from the research, if known; and potential economic implications of the advance, if known. This information will provide a perspective for where an advance fits in within the continuum of medical research, and its potential contribution to understanding and improving human health.

Additionally, when agencies must rely on descriptive criteria, performance assessment must be capable of satisfying a test of independent confirmation. To provide for this, NIH is developing an independent review process that will draw extensively on outside expert input. This process will operate to: 1) evaluate the advances, discoveries, and impacts that have resulted from research conducted or supported by NIH, as reported in NIH Performance Reports; 2) compare these outcomes with the performance goals for the Research Program; and 3) report on the status of NIH's achievement of these performance goals.

The assessment of research outcomes will be the responsibility of a specially-established subcommittee of the Advisory Committee to the Director (ACD) of NIH. ACD members are senior level scientists and administrators with substantial research and policy experience and a broad view of biomedical research. They will be joined on the subcommittee by representatives of the external medical and scientific communities, health care providers, patients, and other members of the public. In the broadest of terms, the panel's assessment will involve gauging the extent to which NIH's stewardship of the medical research enterprise leads to important discoveries, new knowledge, and improved techniques within and across key science fields, and to the aggressive application of this scientific progress to enlarge the options for disease prevention, diagnosis, and treatment.

Data Issues

The vast majority of the Performance Goals in the FY 2000 Annual Performance Plan involve specific targets which enable the objective/quantitative performance assessment that GPRA intends. The criteria and data sources to be used for these assessments vary by the goal, and are described in greater detail in NIH's full performance plan document. Generally speaking, these assessments will depend on data currently available to NIH or upon evaluations that will be specially commissioned for the purpose of assessment. NIH maintains a number of large scale databases that track operations in a variety of areas (such as extramural research contracts, research abstracts, administrative/purchasing information, various measures for technology transfer). Other resources include the studies and reports developed by and for the use of peer review and advisory councils and other distinguished independent panels and

committees to help chart scientific directions and select the most promising research for support. Additionally, objective evaluation is already a well established component of NIH's regular planning and management activities in most all of its activity areas. Such studies are often used to provide basic data on program performance, identify avenues for program improvement, and consider the implications of emerging issues on program operation. NIH also conducts a number of special evaluation studies in conjunction with such agencies as the National Academy of Sciences and the National Science Foundation – such as large scale, long-term studies of scientific personnel and training needs, research facilities and research instrumentation.

Key Improvements to the FY 2000 Plan

NIH's Performance Plan for FY 2000 follows the same basic structure and format of the 1999 Plan. Nonetheless, a number of changes have been introduced this year to provide greater focus and supporting information, and to respond to the evolving guidance from HHS, OMB, and others regarding what a useful Performance Plan should contain.

These modifications principally involve the following:

- The performance goals are more specific and better reflect the agency's most critical activities.

- The Plan has been expanded to include a section which provides NIH's overall strategic framework.

- Where a performance goal continues from the previous fiscal year, appropriate linking information is provided. Generally, this year's Plan provides a comprehensive description of the flow of performance goals and targets across FY 1999 and 2000.

  A descriptive discussion has been included for each performance goal that provides background information and an explanation of the goal's broader significance.

  A plan for performance assessment is outlined for each goal -- including criteria, analytical approach and sources of data.

  Improvements have been made in format to improve the document's reader friendliness, such as a summary table at the head of each performance goal section that provide a comprehensive list of performance goals, targets, and citations to the pages where full details can be found.

  Means goals for Collaboration & Coordination were removed as a whole. Activities of this nature are an overall NIH strategy and were inappropriately identified as Research Program means goals in the FY 1999 Plan. This revised approach is consistent with the principles adopted by other HHS OPDIVs. (There is considerable collaboration with HHS OPDIVs and other federal research organizations in both the Research and the Research Training and Career Development programs. Therefore, collaborative activities will be reported in many goals.)

Substance Abuse and Mental Health Services Administration

Overview

The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Nation's health system is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illnesses. SAMHSA's priorities are:

- Supporting and contributing to the improvement of community-based systems of mental health care.
- Reducing youth substance abuse.
- Assisting States and communities by supporting and helping to improve their substance abuse prevention and treatment efforts.

SAMHSA has an important role in supporting several HHS strategic goals. SAMHSA efforts to reverse the upward trend and use of marijuana among 12-17 year olds and reduce tobacco use among teens and preteens are integral to the Department's strategic goal to reduce major threats to the health and productivity of all Americans. Similar are SAMHSA's activities to support prevention and early intervention for substance abuse. HHS's goal to assure access to needed services is supported by SAMHSA's efforts to implement effective systems of care for children with serious emotional disturbances. SAMHSA, through its Knowledge Development and Application program, is sponsoring a number of research projects which test prevention, treatment and delivery approaches in support of the HHS goal to improve the quality of health care.

SAMHSA's mission and objectives are accomplished through two basic types of activities: Federal leadership and national policy; and the pursuit of national goals through grants, cooperative agreements, contracts, and interagency agreements with Federal, State, local, university, provider, consumer, family, and other types of entities. Through the substance abuse and mental health block grants and the two mental health formula programs, SAMHSA provides direct funding to States to support services, with considerable State discretion over how funds are used. SAMHSA's Knowledge Development and Application (KD&A) effort is a highly focused program of small, applied research and application projects to answer questions that have been identified by SAMHSA's customers as critical to the improvement of services at the point of delivery.

SAMHSA works with a broad array of partners and stakeholders, including State and local governments; providers; consumers/clients of substance abuse and mental health services; family members of individuals with substance abuse or mental illness; grantees; other Federal agencies; foundations; and a variety of volunteer and other organizations that do not fall within the categories mentioned.

The agency also relies heavily on interagency collaborations to accomplish its goals. Other HHS agencies with which SAMHSA collaborates include the Health Care Financing Administration, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the

National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Mental Health. SAMHSA also works with the Office of National Drug Control Policy; the Department of Education; the Department of Veterans Affairs; the Department of Justice; the Department of Transportation; the Department of Housing and Urban Development; and the Department of Defense.

Approach to Performance Measurement

The SAMHSA performance plan is organized around its program areas (i.e.,substance abuse prevention, substance abuse treatment, and mental health) and its funding approaches (i.e., grants, research projects). In all cases, constraints exist in the current state-of-the-art of performance measurement. The need to develop outcome performance measures for these fields is supported by the 1997 report of the National Academy of Sciences entitled "Assessment of Performance Measures for Public Health, Substance Abuse, and Mental Health." SAMHSA is working with States and other partners to address this issue. In addition to the difficulty and expense in identifying and collecting data for appropriate outcome measures, health systems must choose between sustained investment in this effort and using the same dollars to fund additional services.

SAMHSA pilot projects have led to progress in developing performance measures for SAMHSA's block grants. States will submit performance information, on a voluntary basis, as part of the FY 1999 and future Community Mental Health Services Block Grant application. Approval will be sought from OMB in FY 1999 to collect similar performance information on a voluntary basis through the FY 2000 and future Substance Abuse Prevention and Treatment Block Grant applications. Finally, the expanded National Household Survey of Drug Abuse will complement the development of these performance outcome measures development efforts by providing State-level estimates of the prevalence of drug abuse.

For KD&A projects, SAMHSA has outcome measures for some mental health and substance abuse prevention and treatment efforts prevention efforts, and is using output measures for all projects, such as whether topics identified are judged to be important and potentially useful by stakeholders, and whether the work is completed with reliable results based on expert judgments and acknowledged standards of research. For addressing the KD&A issue of translating knowledge and best practices into positive consumer outcomes, SAMHSA has developed appropriate intermediate outcomes including customer ratings of the appropriateness and usefulness of the products and direct adoption of new approaches by SAMHSA-funded entities.

Data Issues

SAMHSA has actively pursued the development of outcome measures for all of its programs. However, the cost to States and to the Federal government of developing and implementing data and other measurement systems for the block grants is expected to continue to be a significant factor in the ultimate success of these efforts.

Key Improvements to the FY 2000 Plan

SAMHSA's FY 2000 GPRA Performance Plan improves upon the FY 1999 plan in several respects. For example:

The plan includes developmental outcome performance measures for mental health programs. These measures that focus on specific improvements in well being for individuals served under the Community Mental Health Services Block Grant, have been piloted through programs funded by CMHS, and have been cleared by OMB for voluntary collection of data through the FY 1999 and subsequent Community Mental Health Services Block Grant applications.

The plan also includes developmental performance measures for substance abuse programs. The set of potential outcome measures identifies specific improvements in well being for children and adults who receive services under the Substance Abuse Prevention and Treatment Block Grant. The test measures have been developed by SAMHSA and the States; and they will be piloted through programs funded by CSAT for future use for the Substance Abuse Prevention and Treatment (SAPT) Block Grant and other purposes. SAMHSA hopes to obtain OMB clearance for voluntary collection of this information through the FY 2000 and subsequent SAPT Block Grant applications.

In many cases, measures that will yield more valuable performance information have been added to the FY 2000 plan or substituted for those in the FY 1999 plan.

Program Support Center

Overview

The mission of the Program Support Center (PSC) is to provide a wide range of support and administrative services to components of the Department and other Federal agencies. The PSC is a business-type operation that provides human resource, financial management and administrative services to its customers.

The broad goals of the PSC's annual performance plan focus on improving the cost competitiveness and quality of its services. These goals and the specific performance objectives in the plan are linked indirectly to the goals of the HHS strategic plan. By achieving its goals and objectives, the PSC will provide services that enhance the capabilities of HHS program components to meet their missions and programmatic goals and objectives. In FY 1999, the PSC will reduce the unit costs for a number of services by consolidating operations, automating more of its workload and increasing its client base. The PSC will also improve customer satisfaction by improving the overall quality of operations and responding to customer priorities and concerns. High quality and less costly internal operations will help HHS programs and agencies to concentrate more attention and resources on achieving results and resolving programmatic issues.

Key Improvements to the FY 2000 Plan

PSC's FY 2000 Performance Plan reflects revisions and improvements to the FY 1999 Plan. Following the initial submission of the FY 1999 Plan to OMB, PSC reviewed and modified it to ensure that each of PSC's major activities included performance measurements in the following categories: (1) unit cost; (2) timeliness; (3) quality; (4) customer satisfaction; and (5) increase in number of customers. The revised plan was included in PSC's FY 1999 Congressional Justification, and PSC continued to evaluate and refine the validity and usefulness of its performance measurements. PSC made revisions and refinements in the FY 2000 Plan to present measurements in a clearer, more readable format. For example, PSC established a performance measurement numbering methodology that allows the reader to immediately identify the function related to the measurement. As PSC reviews the results of performance measurements and gains experience in gathering baseline data, it will continue to refine and improve the FY 2000 Performance Plan.

Office of the Secretary

Overview

Two components within the Office of the Secretary (OS) which have significant and separate programmatic responsibilities and budget submissions -- the Office for Civil Rights (OCR) and the Office of Inspector General (OIG) -- have prepared separate Annual Performance Plans. Four Staff Divisions (STAFFDIVs), encompassing almost two-thirds of total Departmental Management funding, have developed performance goals and measures that have been incorporated directly into the budget requests for those offices. These STAFFDIVs are the Office of Public Health and Science (OPHS), the Assistant Secretary for Management and Budget (ASMB), the Assistant Secretary for Planning and Evaluation (ASPE) and the Departmental Appeals Board

OCR's performance objectives are primarily supportive of the Department's strategic goal to improve access by identifying and eliminating discriminatory practices in HHS programs and by HHS grantees. OIG's primary link to the HHS Strategic Plan is to assure the integrity of the Nation's health entitlement and safety net programs. While OIG will be deterring fraud, waste and abuse, it will also be recommending systemic improvements to HHS programs which will indirectly assist these programs in meeting their own programmatic performance goals and objectives. Many of the ASMB performance objectives address high-priority management areas (e.g., improving grants and contracts administration and financial management, achieving progress in implementing GMRA and ITMRA). A number of the ASMB goals are highlighted in the management improvement analysis in this summary. The Office of Public Health and Science presents a significant set of goals associated not only with the program areas they manage, but also reflecting the leadership role of the Surgeon General. ASPE's objectives highlight analyses, evaluation and policy research on issues of interest to the Secretary.

Key Improvements to the FY 2000 Plan

For the FY 2000 HHS Performance Plan, the OS components have focused on refining their goals and measures for both FY 1999 and FY 2000, particularly on establishing baselines and targets. Key improvements include:

- Under the leadership of the ASMB, the HHS financial management community has revised the HHS Financial Management Five-Year Plan, covering FYs 1999 through 2003, to include concise, quantifiable goals and performance measures for financial management activities throughout the Department. Financial management activities covered in the plan include a wide array of functions that affect or contribute to the financial condition and resources of HHS programs, for example, budget, information management, acquisition, grants, logistics, and human resources functions, as well as the traditional finance functions.

- OPHS has greatly expanded its FY 2000 performance plan, to focus on the outcomes of its activities. The FY 2000 plan is organized around six key public health priorities. For each priority section, the plan lists the OPHS program offices that contribute to goal achievement, a brief description of significant OPHS contributions and the context for performance, a listing of performance measures with baselines and targets for performance, and links of OPHS measures

with the HHS strategic plan. The majority of performance measures have been selected from among the nationally recognized health objectives of *Healthy People 2000/2010* – the State-of-the-art for consensus on population-based health status outcomes.